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SURGERY OF THE PANCREAS.¹

WITH ESPECIAL CONSIDERATION OF TRAUMA AND INFLAMMATORY PROCESSES.

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OPERATIVE interference for disease of the pancreas is still at the present time the most incomplete chapter in the realm of abdominal surgery. It is scarcely twenty years since Gusenbauer described the first operation for cysts of the pancreas. For many years the surgery of this organ was confined to the treatment of this affection, which was a comparatively easy task so far as the technique was concerned. In regard to the other pancreatic affections, as trauma, inflammatory conditions, and new growths in the narrowest sense of the word, it is only in the last ten years that surgical treatment has been seriously undertaken. So recently as 1891 and 1892, the anatomists von Gerlach and Joessel dismissed the subject of the topographical anatomy of the pancreas in a few words, stating that the organ had no clinical interest, as it was almost impossible for the surgeon to reach it.

Still another difficulty presents itself to the surgeon who reports on affections of this organ. When we make an exception of the cystic condition, it is very seldom that one,

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with our present knowledge, has an opportunity to operate upon the diseased pancreas. Hence, the personal experience of each surgeon is only small, and a comprehensive report must rest in a great measure upon the observations of others. When I look over the notes of my own cases of pancreatic surgery during the last twelve years, I find that there are about sixty. This considerable total for a single surgeon is, however, materially reduced when I exclude thirty cases in which malignant disease of the stomach, for which I did resections, had involved the pancreas. However, the observations made in these cases are not without importance to our subject, and I shall refer to them later.

When we seek the cause of the tardy development of the surgery of the pancreas, we find we can ascribe it principally to three general reasons which we must consider carefully, as they show us that which we may expect from this branch of surgery in the future.

First, the topographical relations of the organ should be considered. The hidden and protected position of the pancreas accounts for the infrequency with which it is injured. When such, however, is the case, there usually exist severe complicating injuries of neighboring organs, and the patient very often dies either from shock or from haemorrhage before the surgeon has the opportunity to interfere. But when the abdomen is opened in such cases, the accompanying injuries of the surrounding parts almost always demand such attention that the lesion of the pancreas is easily overlooked. Its protected position makes the technique of bringing it, or portions of it, to the surface of the body exceedingly difficult when no changes from disease are present which approximate the organ to the abdominal walls, for example, in pancreatic cysts. We possess, therefore, no such typical operative methods like those which we employ in exposing the kidney, gall-bladder, or vermiform appendix, whereby the pancreas can be made accessible, and which would be looked upon as normal methods. According to the location of the diseased part and to the enlargement of the organ in a certain direction, we are compelled

to reach the pancreas by various routes, and in this we are, moreover, hindered by the interposition of many organs that surround it.

The operative methods by which we can expose the pancreas may be divided into two general groups: first, the transperitoneal, and second, the retroperitoneal.

In the transperitoneal methods, one enters through a median or lateral incision in the anterior abdominal wall, and then either through the gastrocolic ligament, the ligamentum gastrohepatum, or, after pushing up the omentum and transverse colon, through the mesocolon. In each case the omental bursa is opened. A fourth transperitoneal method (employed by Koerte) is to force one's way along the side of the duodenum, the peritoneal covering of which must first be incised. By this last method, of course, only the head of the pancreas can be conveniently exposed. The retroperitoneal methods aim to reach the pancreas by incisions in the lumbar region. By this means one is enabled to expose only the head or tail of the organ, and the method should therefore be employed only when through changes by disease the affected part is pushed farther to one side or is enlarged as in abscesses, cysts, or tumors.

Another difficulty which we have to contend with results from the location of the pancreas, owing to the possibility of severely injuring surrounding organs when we attempt to reach the pancreas. Besides the stomach and transverse colon, which lie in front of the pancreas, the common bile-duct, the duodenum, and the large blood-vessels demand attention; not less the middle colic artery, the injury of which is followed by gangrene of the transverse colon, a fact which Kroenlein has first demonstrated by his anatomical studies.

Another fact which has prevented the advancement of pancreatic surgery is the difficulty in diagnosis. Here, also, the concealed position of the organ is the main obstacle. The result of examination by palpation is often absolutely negative, in most cases indefinite, and, even when the organ is much enlarged and readily felt by the hand as the result of disease, the interpretation is usually uncertain.

The subjective symptoms are just as indefinite. I must not permit myself to discuss further the difficulties of diagnosis. I only wish to advance the statement that the surgeon cannot rely on the disturbance of function, in most cases, as a diagnostic sign of value. According to our experience, signs of functional disturbance in this enormously important organ do not appear until the greater portion of the gland is affected. Then the surgeon has no longer any right to interfere, for, when once a pancreatic diabetes or symptoms of severe disturbance of its fat-digesting function develop, the patient is, as a rule, beyond the help of operative measures. Experience, in fact, has shown that in affections of the pancreas, which have been treated surgically, positive functional disturbances have been observed only in rare instances. The surgeon cannot, unfortunately, watch the further course of the disease as the medical clinician does, but he must, on the contrary, decide upon the operation, particularly if it be a question of surgical interference, while the general condition of the patient is still satisfactory. So at the present time most cases are operated upon when the diagnosis is only probable, and only after the abdominal cavity has been opened can a differential diagnosis be made. As is well known, in the beginning of the era of pancreatic surgery, most operations were undertaken on a false diagnosis; to-day, as soon as an affection of the pancreas is deemed probable, it is considered wise to submit the patient to an exploratory laparotomy. This practice, fortunately, is of no great consequence, because, as a rule, when the pancreas is intact, we find other injuries or diseases present which justify laparotomy.

A third reason which has prevented the rapid development of pancreatic surgery is that the operation, so far as it includes the organ itself, is much more dangerous than an operation upon any other abdominal organ. This is partly the result of the fact that in most diseases of the pancreas, with the exception of cysts, the general condition of the patient is so low that his recuperative powers are markedly diminished.

A further danger lies in the peculiar physiological char-

acter of the gland itself. Two points come into consideration here. The pancreas is very rich in blood-vessels, and haemorrhage from an injury is difficult to control. Simple tying of the fragile tissues is insufficient, and one must stop the bleeding with sutures deeply buried in the tissues and including much of the latter, which has the disadvantage of causing the parenchyma to necrose, thereby creating conditions which will be shortly discussed.

In spite of deep sutures and heavy ligatures *en masse*, blood and pancreatic secretions ooze into the peritoneal cavity, preventing the formation of peritoneal adhesions, which in abdominal operations in general are so important a protection. Secondary haemorrhage into the peritoneal cavity is very apt to occur. Several operations are recorded in medical literature which seemed to promise a favorable result, but which ended fatally from this complication.

A danger much greater than that from haemorrhage complicating operations on the pancreas is that due to the special secretion of the gland leaking from the injured parenchyma in larger or smaller quantities. The point as to whether or not this leakage is injurious was only recently definitely settled. After the experiments and experiences of recent years, we can no longer doubt that such leakage is indeed harmful. The experimental studies of Williams, Flexner, Biondi, Katz and Winkler, and others, show clearly that injuries of the pancreas, through which the vitality of a part of the organ is impaired, and the flow of pancreatic juice towards the pancreatic duct is hindered or ceases entirely, seriously affect the peritoneum and the neighboring tissues. Fat necrosis, as well as the various forms of pancreatic inflammation, from a severe haemorrhagic pancreatitis to a chronic induration, may be experimentally produced in animals by such injuries. A number of reliable clinical observations are on record, in which, after accidental injuries, changes were present in the pancreas and the neighboring organs similar to those which we have just considered in connection with the experimental work on this subject. When death does not ensue from haemorrhage in

such cases, a fatal result may occur from the acute, subacute, or chronic forms of pancreatitis following such injuries. I can mention in this direction the observations of Simmonds, Schmidt, Hahn, Gessner, Pressel, Sendler, Groeningen, Leith, Ziegler, and Selberg. Even after injury to the organ during operation, fat necrosis has been observed, as in Koester's case. That enormous quantities of pancreatic secretion can escape from the wound surfaces of the pancreas is proved by the interesting cases of Ruggi and Biondi, who resected a large portion of the pancreas for a malignant tumor and drained the wound.

How much worse the prognosis of an operation becomes when the pancreas has been injured is shown by my statistics of gastric resections in cases of cancer. In ninety-one cases of resection of the stomach where the pancreas was certainly not injured, twenty-five, or 27.5 per cent., died as the result of the operation. In thirty other cases the pancreas was injured. This was usually due merely to freeing the tumor from adhesions to the pancreas. The parenchyma of the pancreas, however, was exposed and communicated freely with the abdominal cavity. In other cases pancreatic lymph glands or superficial parts of the pancreas were removed. Of these thirty cases, twenty-one, or 70 per cent., died, mostly of peritonitis.*

If we ask ourselves whether the secretion from the injured pancreas leaking into the abdominal cavity can of itself so damage the peritoneum that death from this cause alone may result, we must surely admit that this is a possibility, as shown by a number of experiments and clinical observations of accidental injuries in man. The pancreatic juice mixed with blood has, no doubt, a very toxic effect and can, in the so-called apoplexy of the pancreas, result fatally without the complication of bacterial infection.

* It might be said that the mortality of these thirty cases was high on account of the severity and length of the operation. This objection would be just, if the majority of cases had died in collapse, which was not the case. As already stated, the majority died of peritonitis.

In the majority of cases, the secretion from the pancreas—I do not refer to the normal physiological secretion, but rather to the exudate from the injured organ—does not flood the abdominal cavity in such quantities that it will prove fatal by mere absorption. It acts indirectly by reason of the local irritation of the peritoneum in that it prepares a nutrient medium for bacterial invasion and makes infection extremely easy.*

Even with the present status of our aseptic technique it is not possible to prevent all germs from reaching the abdominal cavity during laparotomy. An uninjured peritoneum will resist this infection if the germs are not introduced in certain quantities. But if the vitality of the peritoneum has been impaired by the action of the pancreatic secretions, then a very limited number of bacteria are sufficient to cause peritonitis.

There is also in every case of injury of the pancreas, the danger of a retrograde infection from the duodenum through the ductus pancreaticus. It seems, moreover, that the secretion from the injured, or also inflamed pancreas without bacterial invasion, can cause a variety of aseptic peritonitis. This is frequently followed by a paralysis of the intestines, leading to rapidly developing intestinal obstruction which often so modifies the symptoms as to lead to a serious mistake in diagnosis.

I speak of this point more in detail because I consider it

* Not only the normal constituents of the pancreatic juice, chiefly pancreatin and steapsin, come into consideration, but also the direct degeneration products of the dead gland cells. The latter should not be confounded with the pancreatic secretion, as has apparently been done by a number of experimenters; for example, Senn decided, from his experiments in which he made an internal pancreatic fistula, that injuries of the pancreas are without special influence upon the abdominal cavity. It is not correct to assume that the juice of any crushed or powdered gland is identical with its normal secretion. A large number of investigators have observed that when the excretory duct of the pancreas is ligated, and retention of the glandular secretions results, the typical signs of fat necrosis of the pancreas do not appear. This is explained by the fact that the normal or nearly normal secretion is carried away in the lymph and blood stream, where its ferment are rendered harmless, as the investigations of von Nencki and Tschepurkowski have shown.

of great importance in pancreatic surgery. For whatever operation may be done on the pancreas, we must take the greatest pains to keep the secretion of the injured gland from getting into the abdominal cavity. This can be done in two ways: first, one can turn the injured part inward and close it with deep sutures so that the peritoneal covering is again in continuity. Ninni used this method with good results in a gunshot wound. As a rule, however, this will not be possible, or, at least, will not offer a sufficient protection against leakage of the pancreatic juice into the peritoneal cavity. Nothing more can be done in these cases than to protect the latter by means of tampons reaching down to the exposed pancreas.

The value of this tampon drainage is demonstrated to-day by the limited number of wounds of the pancreas which have been operated upon. Of twelve injuries, partly the result of blunt force, of stab or gunshot wounds, eight were drained.* Of these six recovered and two died. Of the four undrained cases, three died, only the previously quoted case of Ninni recovering.

When capillary drainage of wounds of the otherwise healthy pancreas is so important, there can be no doubt of its greater value in operations upon the diseased organ. This obtains not only in acute and chronic inflammatory conditions due to bacterial infection, but also in certain aseptic lesions which present themselves to us clinically as pancreatic apoplexy in the most acute cases, or in the more chronic as pancreatic cysts. The admixture of blood to the pancreatic secretion in the peritoneal cavity renders the condition more serious. We see, therefore, that when patients survive the acute stage of the disease, whether septic or aseptic, this is accomplished only

* These are the cases of Hahn, Deutsche Zeitschrift für Chirurgie, Band lviii, 1901. Küttner, Beiträge zur klinischen Chirurgie, Band xxxii. Villiere, Bulletin de la Société Anatomique de Paris, Band lxx, 1895. Rose, Deutsche Zeitschrift für Chirurgie, Band xxxiv, 3, 36. Hadra, New York Medical Record, 1896. Von Mikulicz, Vierteljahr-Schrift für gerichtliche Medicin (3), xviii, 2. Michaux, XIII Internationale Medicinischer Kongress zu Paris. Cushing, ANNALS OF SURGERY, p. 69 (1898), page 337.

through the walling off of the focus of disease by peritoneal adhesions.*

I have attempted to collect all operations for acute disease of the pancreas to determine, if possible, the value of drainage also in such cases. I have succeeded in finding thirty cases. In twenty-seven of these, it is distinctly stated that the exposed pancreas was drained; of these, eleven, or 38 per cent., died. In the remaining number, either no drainage was established, or exact statements are lacking. Of these, forty-one, or 80 per cent., died.†

From these statistics, we should conclude that wherever the pancreatic tissue has been exposed at all, the abdominal cavity must be tamponed, and drainage established.

After these general remarks, we will proceed to the special part of our subject. We can divide pancreatic diseases which concern the surgeon into three great groups: (1) Injuries; (2) inflammatory processes; and (3) new growths.

In the second group I would include also pancreatic apoplexy and pancreatic calculi; in the third group we will place in addition to tumors, as is generally customary, the pancreatic cysts which, although in a great number of cases of traumatic origin, in others are certainly due to small apoplexies or to an inflammatory condition.

As I have repeatedly spoken of the injuries of the pancreas, I can now be more brief, particularly as the number of cases on record is even, at the present time, very small. The

* Recently Pierre Achalme has made experimental studies on the action of pancreatin in the peritoneal cavity. He tried to discover whether the blood serum of the animal experimented upon did not possess some anti-fermentative virtue, and if it could produce immunity when given in increasing doses. He was not only successful in rendering animals thus treated immune against toxic doses of pancreatin, but also in obtaining a serum that immunized other animals. Perhaps a serum acting similarly on human beings might be obtained. This would enable us to protect the patient to be operated upon against the harmful effect resulting from absorption of his own pancreatic secretions.

† In the last category, it is possible that a number of drained cases are included, and therefore the resulting mortality turns out too favorable.

problem presented to the surgeon by an injury of the pancreas to-day is very clear. We have first to stop the haemorrhage, and secondly, to prevent, as much as possible, the flow of pancreatic secretion into the abdominal cavity and the subperitoneal tissues. The first and, to some extent, the second problem will be solved by deep sutures and ligatures *en masse*. Where a break in the continuity of the organ through a stab or gunshot wound occurs, we close the wound with deep sutures, and thereby best control the bleeding and leakage of pancreatic secretions. When the pancreas, as usually happens by the action of blunt force, is not simply torn but crushed, these means will not be sufficient.

Here, as in all unsutured wounds of the pancreas, we must of necessity use the tampon to overcome the dangers previously discussed. Even when the wound is sewed, tamponing is to be recommended, especially when neighboring portions of the stomach or intestines are injured, this being a frequent complication. In spite of prompt suturing of wounds of the stomach and intestine, the danger of peritonitis is very great.

The diagnosis of these cases can rarely be made with any degree of certainty. The difficulties which we contend with in this respect are so great owing to the fact that in most cases the neighboring organs are also injured. In cases which come under observation very soon after injury, we can only suspect a lesion of the pancreas. The surgeon must, however, always bear in mind the possibility of injury to the pancreas in all cases where the force has acted upon the epigastric and umbilical region. He must always direct his attention to the pancreas if, after opening the abdomen, he finds a lesion of another organ, such as the stomach. We often find cases reported where, wounds of the stomach or intestines having been sutured, death has occurred from an undetected wound of the pancreas.

With the uncertainty of diagnosis it is best to make the incision, as a rule, in the median line above the umbilicus. This is also true for penetrating wounds which lie some distance from the median line. From this median incision one

can best determine what changes are present in the peritoneal cavity, and can enlarge the incision above, below, or to one side, as needed, exposing the injured pancreas according to the location of the injury. Then we can proceed as in wounds of other abdominal organs. I want, in this connection, to mention the great importance of thoroughly washing out the peritoneal cavity with warm normal salt solution (0.9 per cent.).

I have found in all forty-five cases of pancreatic injury, twenty-one penetrating wounds and twenty-four subcutaneous wounds from blunt force. Of the twenty-one penetrating wounds, twelve were of gunshot origin and nine were stab wounds. Of the gunshot wounds, five were operated upon, two dying and three recovering. (The cases of Otis, Hahn, and Ninni.) The seven that were not operated upon died. The nine stab wounds were all operated upon, one dying and eight recovering. This remarkably favorable percentage of recovery in the stab wounds is to be explained by the fact that, in seven cases, the pancreatic injury was really a prolapse, and in some of these cases only a very minor lesion of the prolapsed portion was present. The evil consequences of injuries to the pancreas within the peritoneal cavity could therefore not follow. The operation in seven cases of pancreatic prolapse consisted in excision of the dislocated portion in five cases and reposition in the other two cases. An intra-abdominal punctured wound of the pancreas occurred only in the cases of Hildebrand and Küttner. In the latter recently published case, the organ was almost completely divided in an anteroposterior direction. Küttner united the divided pancreas by means of two deep and one superficial suture; the haemorrhage stopped at once; then a wound in the stomach, nine centimetres long, was sewed up, and finally the omental bursa was drained with a tampon. The case recovered, even though it was complicated by the formation of a subphrenic abscess.

In Hildebrand's case there was also a perforation of the stomach in addition to the injury to the pancreas. The wound in the stomach was sutured and the bleeding vessels of the pancreas were ligated. No drainage was established, and the patient died four days after laparotomy.

Of the twenty-four subcutaneous injuries, thirteen were not operated upon and all died. Of the eleven operated on, seven recovered. Three cases were operated upon early, within four days after the injury. One of these recovered (Hadra) and two died (Villiére, Michaux).

The operation consisted in exposing the injured pancreas and in drainage; eight times the operation was done late. After one or more weeks the haematoma arising from the pancreatic wound was opened and partly drained. Two cases died (those of Braun and Czerny) and six recovered (the cases of Rose, Mikulicz, Stern, Lissjanski, Michailow, Cushing, and Kuhlenkampf).

These figures include only the severe contusions of the pancreas in which the diagnosis was confirmed by autopsy or by an operation undertaken sooner or later. There is, therefore, no doubt that not infrequently slight contusions of the pancreas result from injury which either heal spontaneously or cause only minor disturbances. We must assume this possibility from experiments on animals. The cases in which trauma play an important rôle in the etiology of the different forms of acute and chronic diseases of the pancreas also teach us this lesson. This is especially the case in pancreatic cysts, of which about one-fourth are of traumatic origin, or, at least, referable to traumatic haematomata. Not every injury of the pancreas justifies a bad prognosis, nor does it warrant us in assuming that immediate recourse should be had to operative interference. The indication for operation does not only depend upon the diagnosis of an injury to the pancreas itself, but also upon the severity of all the symptoms, especially and particularly the steady accentuation of such symptoms. These symptoms are increasing anaemia, the physical signs of blood in the abdominal cavity, and peritoneal irritation. An injury to neighboring organs can frequently occasion the same symptoms, as I have previously stated, and, as a rule, it is not important to diagnose that the pancreas itself is injured. The diagnosis of an abdominal injury which can result in the death of a patient from haemorrhage and peritonitis is in general suffi-

cient. No definite rules can therefore be laid down as to whether one should await further developments or proceed immediately to laparotomy in any given case. The suspicion of a severe injury to the pancreas should encourage us to act quickly.

The figures previously mentioned, small as they are, teach us that severe injuries to the pancreas, which are not submitted to operation, terminate fatally almost without exception. They also teach us, in view of the favorable results obtained up to the present time, to make an exploratory laparotomy whenever there is a question of severe pancreatic injury.

We will now proceed to the inflammatory lesions of the pancreas.

A very excellent pathological classification of acute pancreatitis by Fitz has stimulated further research on the subject. That author divided pancreatitis into the haemorrhagic, the suppurative, and the gangrenous varieties. This division is, however, not the best for the clinician. These three forms of pancreatitis, easily differentiated as they are in typical cases, merge into one another in most instances, or follow each other in succession. Even pancreatic apoplexy is very difficult to differentiate from haemorrhage pancreatitis.

Furthermore, the acute and subacute forms of pancreatitis frequently border on chronic pancreatitis. I should, therefore, rather accept the classification of Robson from the clinical stand-point of acute, subacute, and chronic pancreatitis. The classification of Fitz into haemorrhagic, suppurative, and gangrenous pancreatitis rather represents different stages of the disease, with a common etiology.

Let us now turn to acute pancreatitis, and first of all inquire if it is purely an infectious process, and whether it is exclusively the result of an invasion of bacteria. Without doubt, bacterial infection in acute pancreatitis plays an important rôle, but it does not alone explain the singularly severe symptoms. In this connection, the cases of genuine pancreatic apoplexy, which run their course as an acute haemorrhagic pancreatitis, are of great importance. As is well known, a severe

haemorrhage from the pancreatic and retroperitoneal cellular tissue occurs in these cases, as the result of a peculiar dyscrasia of the patient, accompanied by haemorrhagic peritoneal exudation, which is not of bacterial origin.* That a haemorrhagic diathesis, or that other predisposing factors, as alcoholism, arteriosclerosis, syphilis, or fatty degeneration of the organ in obesity, play a great rôle, is not to be doubted, but does not explain the nature of the process. If we look for an analogous condition, we find it, as the term "apoplexy" expresses, only in the spontaneous haemorrhages in the brain, but here the severe local reactions are missing.

There can be no doubt that there is in addition to the haemorrhage some special cause for this phenomenon. We may not be amiss in attributing it to the action of the pancreatic and fat-splitting ferments upon the gland, which is the seat of an haemorrhage or has been otherwise injured.

As a result of a slight blow, the following vicious circle may develop not only in those unusually rapidly fatal apoplexies, but also in small and harmless haemorrhagic foci (of traumatic and non-traumatic origin): small haemorrhages or disturbances in circulation (from arteriosclerosis, embolus, thrombosis); from this necrosis of a small area of the gland; infiltration around this focus of the ferments set free by the destruction of the parenchyma cells; digestive changes in the surrounding tissue and its vessels which were, until this time, unchanged; enlargement of the haemorrhagic focus, partly as a direct result of the erosion of the vessels, and partly as the

* Hlava found that in so-called pancreatitis acuta, the haemorrhagic exudate in the pancreas, as well as the peritoneum, was sterile. In medical literature the terms "pancreatic apoplexy" and "acute haemorrhagic pancreatitis" are frequently confounded, which can be explained by the great similarity of the clinical course as well as the anatomical findings in both affections. My opinion is that a sharp differentiation can only be based upon a bacteriological examination. The one is an aseptic, the other a septic process. The possibility of transitional forms lies in the fact that an infectious pancreatitis assumes a severe haemorrhagic character as the result of a dyscrasia similar to that which we see in a pure pancreatic apoplexy.

result of the undermining of the tissues and the increased pressure from the haematoma; necrosis and destruction of the surrounding parenchyma of the gland; further escape of the ferments, etc. The tendency to successive enlargement of all existing haemorrhagic foci is present beyond doubt. It has already been mentioned in speaking of the difficulty with which traumatic haemorrhage from even small vessels of this organ is controlled.

Whether a primary focus involves only a small area and heals naturally; whether it slowly enlarges and later, after weeks and months, forms a pancreatic cyst, or finally gives rise to pancreatic apoplexy, depends on the resistance of the vessels and the interstitial connective tissue (fatty degeneration of this tissue is known to be a predisposing factor); upon the digestive activity of the escaping ferment, and, finally, upon the anti-fermentative property of the blood serum and the other body fluids.

I should like to emphasize the fact that in true pancreatic apoplexy, owing to the existing serious constitutional dyscrasia, a surgical procedure would hardly be warranted. As it is difficult, clinically, to distinguish these cases from cases of acute pancreatitis, it will occasionally happen to the surgeon to operate upon the former under a mistaken diagnosis.

If the pancreatic ferments play so important a part, even under aseptic conditions, we can readily understand their intensified action on the tissues when combined with bacterial infection. That these ferments are really of such importance in the development of acute pancreatitis is shown by the frequent occurrence of fat necrosis accompanying this disease. The characteristic features of acute pancreatitis are due, therefore, to the action of the pancreatic ferments.

The surgeon has little interest in the nature of the bacterial infection of the pancreas when the latter is only a part of a general systemic infection. Surgical interference is indicated particularly in those cases in which the pancreatitis is a purely local condition. This, according to our present knowledge, is very often the case. We know to-day, thanks to the researches

of Robson, Opie, and Koerte, that the pancreatic duct, like the common bile-duct, is easily infected from the duodenum. The surgeon should always bear in mind that acute and also chronic pancreatitis often follows cholelithiasis and cholangeitis, as the infection travels from the bile-duct through the ampulla Vateri in a backward direction to the pancreatic duct. Opie has established the fact that a gall-stone can be caught in the ampulla Vateri and close it. Then under favorable anatomical conditions it can produce a retrograde flow of infectious bile into the ductus pancreaticus. Pancreatic calculi can of themselves cause a similar irritation. This, however, in contradistinction to gall-stones, seldom occurs.

The surgeon will accordingly bear in mind the following points in considering the etiology of acute pancreatitis:

1. The very slight tendency of pancreatic haemorrhage to stop spontaneously.
2. The locally destructive and the general toxic action of the pancreatic ferments set free by the inflammatory and haemorrhagic processes, and, finally,
3. The ease with which the pancreas may be infected from the ductus choledochus.

If these propositions are correct, I believe that the course of the surgeon, in order to master the situation, is clear.

We may consider acute pancreatitis as an acute phlegmon which, on account of the peculiar nature of the tissue, runs an unusually severe course. As in an ordinary phlegmon, so in the pancreas, the only rational therapy is to open the focus of infection with the knife and to empty and drain the toxic and infectious exudate. Gauze tampons will best combat the fatal tendency to haemorrhage.

Of course, there are different degrees in the intensity of this process, just as in ordinary phlegmon, where we meet the most severe form of general sepsis as well as the most harmless furuncle. In such cases the surgeon will often refrain from operation when neither the general system nor important tissues or organs in close contact with the infected area are in danger of infection. But when the infection threatens to

spread to vital organs, the surgeon will not dare to rely on spontaneous absorption or wait for the formation of a typical abscess. He must unhesitatingly proceed to lay open the focus of infection with the knife.

Such considerations, I should think, answer the question as to the expediency of surgical interference in the first,—the most acute stage of pancreatitis. We should not in general allow the severe symptoms to pass and delay the operation until the formation of an abscess.

To continue the comparison between acute pancreatitis and acute phlegmon, we can hardly conceive of a region in which the focus of infection could be more unfavorably placed. Not only is the patient threatened with severe toxic and general septic symptoms, but he is also exposed to the danger of a progressive general peritonitis. This is especially likely to develop in the subphrenic space, giving rise to subphrenic abscess. There is also the danger of formation of a phlegmon in the loose tissue of the retroperitoneal region, which is rich in lymphatics. From this, again, other complications arise, such as pyæmia, a phlebitis, or even a pleurisy. Most surgeons, even at the present time, are more or less opposed to early operation in acute pancreatitis, and clinical experience seems to justify their disapproval, for the results of early operation are not as good as those which follow later surgical interference.

Of the cases I have collected, only nine out of forty-six operated upon in the acute stage recovered. On the contrary, eighteen out of thirty-five recovered when the operation was done during the later stages of the disease. I believe, however, such statistics are of no great value.

First of all, we do not know, from statistics available at present, how many of these patients with acute pancreatitis really survive the acute stage and go on to the subacute, the most favorable stage for operation. I believe that comparative statistics in this regard will show that the great majority of the patients die in the acute stage. The possibility that a goodly number could be saved by means of a rationally conducted early operation cannot at the present time be denied. I say purposely

"a rationally conducted" operation, for the operations done up to the present time for acute pancreatitis were not all rational procedures. As we know, most cases have been operated upon under a false diagnosis, and the disease has not even been recognized at the time of operation, the surgeon being compelled to close the abdomen without having relieved the condition of his patient. The post-mortem examination in these cases has first shown the true condition. The operation was usually done, a diagnosis of perforative peritonitis or intestinal obstruction having been made. The suspected perforation or occlusion was looked for; the operator thoroughly explored the abdomen; in many cases the intestines were eventrated, and finally the abdomen was again closed. As a rule, an anaesthetic had been given the patient. It is certain that by such procedures the patient was greatly harmed and not at all, or very little, helped. The evacuation of the haemorrhagic peritoneal exudate alone was of some value.

Only in recent years, since surgeons have learned to recognize the ominous symptoms of fat necrosis and to refer them to an affection of the pancreas, they have ceased to make a thorough search among the abdominal viscera. Most surgeons to-day still close the abdomen when they have satisfied themselves of the existence of fat necrosis, in the conviction that the patient cannot be saved. Only a few surgeons are in favor of active and direct interference with the pancreas.

Nimier has proposed incising the pancreas in acute pancreatitis and introducing a tampon. Later on, Robson recommended early operation, making a small incision below the umbilicus, and, if necessary, a counter-incision at the border of the ribs for thorough drainage. In a similar manner, Lund recommends an incision above the umbilicus, splitting the gastrohepatic ligament, and thus securing free drainage of the omental bursa. When necessary, the vault of the diaphragm may be exposed, and drained by resection of the tenth and eleventh ribs.

I fully agree with these surgeons, for the reasons which I have previously mentioned. We should, at least, try such

methods before admitting that we are powerless in all cases of acute pancreatitis.

The indication for laparotomy in these cases is more readily found by the surgeon, as he cannot in any given case make the differential diagnosis between an acute pancreatitis and other diseases calling for surgical intervention, such as acute perforative peritonitis and acute intestinal obstruction. He must in all such doubtful cases think of the possibility of acute pancreatitis. He will be able to make his diagnosis after opening the abdominal cavity and finding a haemorrhagic exudate, upon determining the presence of fat necrosis, and by manual examination of the pancreas.

Having assured himself of these conditions, he should then proceed systematically, instead of terminating the operation at this time, as was formerly done. Cases of this kind, however, offer great difficulties, and we have yet to learn by experience which procedures will produce the slightest amount of surgical shock in the much-enfeebled patient, while still accomplishing the object for which they were undertaken.

In this connection, I will mention a case of Hahn's (*Deutsche Zeitschrift für Chirurgie*, Vol. Iviii, page 1, 1901), in which that surgeon made an incision below the umbilicus, using local anaesthesia, and, after diagnosing an acute pancreatitis, confined himself to merely evacuating a large haemorrhagic exudate and draining the abdomen with iodoform gauze. The fortunate issue in this case should encourage us to imitate this procedure in all those cases in which, owing to the weakened condition of the patient, it is inadvisable to explore the pancreas itself.

But Hahn's case is not the only one of its kind. As early as 1889, Halsted observed a recovery in a case of acute pancreatitis with fat necrosis of the omentum and mesentery where only a laparotomy and removal of peritoneal exudate were done. The operation was undertaken in the belief that the case was one of acute intestinal obstruction. Four years after operation a similar attack occurred in this patient.

Another case was operated upon by Pels-Leusden in 1901

in König's clinic under similar conditions and with a successful result. The peritoneal cavity was drained.

Finally, Henle, three years ago, operated upon a case in my clinic in which the diagnosis of acute intestinal obstruction had also been made. After demonstrating the presence of an extensive fat necrosis in the omentum, a large peritoneal exudate was removed. An artificial anus in the cæcum was established to relieve the condition of intestinal paralysis. The patient recovered and the artificial anus was closed six weeks later. In the course of the following year similar attacks recurred, but these were always less severe and subsided after high enemata.

This small number of favorable results does not allow us to draw binding conclusions regarding the efficiency of these operations. One could infer that the patients recovered not because of, but in spite of the operation. I believe, however, that even at the present time the following can be stated in favor of surgical interference:

1. The operation according to Hahn, under local anaesthesia, can be performed so easily that we can employ it even in collapsed patients without running any great additional risks.

2. Emptying of the peritoneal exudate and thorough flushing of the abdominal cavity with a 0.9 salt solution are surely of great benefit to the patient, more especially when the peritoneal cavity is later on drained.

3. An artificial anus, according to Henle, should be established only when intestinal paralysis exists.

Whether or not we will in future secure such favorable results with the methods already in use, as were obtained in the four cases of Halsted, Hahn, Pels-Leusden, and Henle, further experience alone will show. It must particularly demonstrate whether the simple operations, which do not directly include the pancreas itself, are sufficient not only to remove the symptoms of intoxication, but also to check the further development of the disease. *A priori*, one must consider an incision into the pancreas followed by drainage as a rational treatment in acute pancreatitis, even as in an acute

phlegmon we make deep incisions to remove tension and expose the focus of infection, or as we open the medullary canal by trephining in the severe septic forms of osteomyelitis before the formation of real pus. The statistics up to date, in spite of these four favorable cases, as far as we may judge, show that an operation which does not disturb the pancreas, favorable as its influence may be on the general condition, does not help materially in combating this terrible disease.*

By active interference in the acute stage, we not alone desire to overcome the septic condition to which most of the patients succumb, but also to ward off necrosis and sequestration of large portions of the gland occurring in many cases. Even should the surgeon be able to remove the disintegrated portions of the gland, the loss of a considerable amount of pancreatic tissue might prove a serious matter to the patient later on. Among the cases of pancreatic necrosis which have been operated on with a favorable result, we find many in which the patients have succumbed to increasing emaciation and pancreatic diabetes from a loss of function of the gland.

So far I have considered only the case of acute pancreatitis, and, speaking generally, I have ventured the opinion that they should be subjected to surgical interference. As I have already stated, this seems to me eminently proper, as a differential diagnosis between acute pancreatitis and other diseases, which also demand immediate laparotomy, is hardly possible.

We must judge the *subacute* forms of pancreatitis somewhat differently. Cases occur in which the first fulminating attack disappears rapidly, or in which the disease begins insidiously at the outset, only gradually developing severe local and general symptoms. Here the surgeon has time to observe his case more carefully, and to consider the advisability of com-

* I have collected seventy-five operations for acute pancreatitis which were performed in the early as well as the late stages of the disease. Of thirty-seven cases in which the pancreas was involved in the operative interference, twenty-five recovered; in forty-one, where the pancreas was not touched, four cases recovered (the cases of Halsted, Hahn, Pels-Leusden, and Henle).

bating the attack without surgical interference; indeed, a delay in most of these cases is not inopportune, as the diagnosis is still more uncertain than in acute pancreatitis.

Chronic inflammations of the pancreas were not regarded as suitable for surgical treatment until a short time ago.

It was first shown by the observations of Riedel, Koerte, Lancereaux, and Hardin, and more especially by the careful work of Robson, Halsted, and Opie, that cases of chronic pancreatitis, which otherwise had seemed hopeless, were not only improved, but also completely cured by operative means. We have learned two things, above all others, in the last few years: first, that chronic pancreatitis runs a course not dissimilar to that of pancreatic carcinoma and has often been mistaken for the latter, and, second, that active interference has often been postponed because we have been unable, as just stated, to properly recognize the condition of chronic pancreatitis, and have confounded it with a condition beyond surgical relief. It is easy to understand how the clinical symptoms of both affections, especially in disease of the head of the pancreas, could show a resemblance. But even after opening the abdomen, the differential diagnosis can often not be made by palpation, since in both cases the diseased portions of the pancreas present a hard, irregular mass enclosed in the gland. Only recently, in a case of that nature, with closure of the common bile-duct by the indurated head of the pancreas, I did a cholecystentero-anastomosis in the belief that I was dealing with a carcinoma. When the patient died ten days later of pneumonia, I learned from a microscopical examination that I was dealing with a case of chronic pancreatitis. In several other cases, during my earlier experience, I have made a diagnosis, with or without operation, of carcinoma of the pancreas, and have in consequence given an unfavorable prognosis. In these cases the patients have recovered. The diagnosis should, of course, have been chronic pancreatitis.

Another no less important point, to which Koerte, Robson, and Opie have called attention, is the close relation existing between chronic pancreatitis and diseases of the biliary tract.

Gall-stones which become impacted near the papilla Vateri, even though small, have an important bearing upon the development of chronic as well as acute pancreatitis. Infection arising from a cholangeitis may spread through the pancreatic duct to the pancreas. On the other hand, a chronic pancreatitis of the head of the pancreas can easily simulate a cholelithiasis by compression of the common bile-duct.

From what has been said, it is evident that chronic pancreatitis must always be considered in making a diagnosis of cholelithiasis; and, further, that with gall-stones and cholangeitis, especially when the common duct is involved, one must be prepared to find a lesion also of the pancreas.

Barring the cases of chronic pancreatitis already discussed, pancreatic calculi are found only in very exceptional cases.

The surgeon should always bear in mind the possibility of a pancreatitis developing as the result of a chronic intoxication (alcohol) analogous to the development of cirrhosis of the liver.

Owing to the uncertainty of the diagnosis of these conditions, an operation should always begin as an exploratory incision. Only after establishing the diagnosis on a firm basis, by local examination, is the surgeon enabled to further develop his plan of operation. He must choose between two ways: he must strive to remove the cause of the disease; this he will do when he finds impacted concretions in the common bile-duct, the papilla Vateri, or Wirsung's duct. The technique of all these operations is not unlike that of cholelithiasis.

As impacted calculi generally give rise to an infectious cholangeitis or an inflammation of the pancreatic duct, drainage, as a rule, of one or both ducts must be provided. One should also drain the neighboring portions of the peritoneal cavity with tampons.

The second way is more indirect, inasmuch as only a free outlet for the confined and infected bile is established. This can be done through a gall-bladder fistula by means of a cholecystotomy when the cystic duct is free, or by establishing a communication with the small intestine by means of a cholecys-

tenterostomy. Both operations have their advantages and disadvantages.

The technique of the first is more simple, and does not permit a permanent infection of the bile-tract from the contents of the intestine. It has the disadvantage that the patient is burdened for a long time with an external fistula, the closure of which may prove difficult. The question as to which of these two operations is preferable has not yet been answered by clinical experience. I want, however, to emphasize that the importance of a retrograde infection of the bile-tract from the intestinal fistula is by no means so great as it may at first appear; this, at least, the experimental work of Radziewski, done in my clinic, would indicate.

The danger of infection is greatly diminished when the plan which I recommended in these cases is employed. After cholecystenterostomy an entero-anastomosis is immediately added at a distance of about ten centimetres from the original anastomosis, which deflects the intestinal circulation from the loop in connection with the gall-bladder.

I should also recommend that the surgeon do not hesitate too long in operating for chronic pancreatitis, as severe disturbances of nutrition can occur following gradual degeneration of the organ. Of course, when only mild symptoms are present, one will not resort to the knife at once, but rather recommend internal medication.

The results of operation at present in chronic pancreatitis are very encouraging. If I include twenty-two cases of Robson, in which there was only one death in connection with the operation, I find thirty-six cases reported, of which thirteen recovered and five proved fatal.

One can treat the subject of surgical interference for pancreatic calculi very briefly, as they are known to be very rare, and, consequently, no very detailed accounts of the experience of surgeons with them are available. I find reports of two cases, both of which died following operation. In one of them the stones were removed from the head of the pancreas and the ductus Wirsungianus. In the second a cholecystentero-anasto-

mosis was done, as a diagnosis of pancreatic calculi was not previously made.

Since a pancreatic stone does not give rise to any characteristic symptoms, and is only recognized as such when passed in the faeces, the surgeon is only concerned with the secondary changes which its presence may cause. These will arise from a blocking of the pancreatic duct or its branches, and will become evident from an accompanying chronic or subacute pancreatitis. The surgeon will find an indication for interference only if symptoms of pancreatitis are present. In all such cases, therefore, we should also remember the possibility of the presence of calculi.

I will now briefly give my personal experience in the field of pancreatic surgery. The thirty cases in which I have had the opportunity of operating upon the pancreas while performing a resection of the stomach for cancer, I have already considered.

Besides these, during the twelve years that I have been in Breslau, I have operated on the pancreas thirty times; ten of these were typical pancreatic cysts, of which two were removed and eight were incised and drained. All recovered.

A subacute pancreatitis occurred twice among these cases, once leading to abscess formation and the second time giving rise to fat necrosis. The abscess healed after incision. The other patient was the one before mentioned as the case of Dr. Henle, who was restored to health after a preternatural anus had been established. He was successfully operated upon without disturbing the pancreas. A case of chronic pancreatitis, also previously mentioned, died of pneumonia ten days after a cystentero-anastomosis. In a case which was mistaken by me for carcinoma, the patient lived four years after the laparotomy.

In one case of contusion of the pancreas, the result of blunt force, twenty-four days after the lesion, an immense haematoma was opened and drained. The case recovered. This case was also mentioned before.

I have observed fifteen malignant growths involving the pancreas. In these exploratory laparotomy was done seven

times and cholecystenterostomy five times. Of the latter, one died as a result of the operation.

Once a gastro-enterostomy was done for a stenosis of the duodenum due to a pancreatic tumor.

Once drainage for a softened tumor which was taken for a cyst was made, and

Once extirpation of a tumor in the head of the pancreas was done. All three cases ended fatally.

Post Scriptum.—A week after I had read my paper before the Congress at Washington, I had the privilege of seeing a case of acute pancreatitis in the Massachusetts General Hospital in Boston, which had been operated on by Dr. C. A. Porter with an excellent result. In this case, for the first time to my knowledge, multiple deep incisions were made into the substance of the pancreas, to relieve tension, in the manner which I have suggested in the present paper. As this case marks the first practical application of a definite surgical principle in acute pancreatitis, I take the liberty of adding a history of the same, as kindly furnished me by Dr. Porter.

S. P., aged thirty-six years, salesman, entered the Massachusetts General Hospital, February 17, 1903, as a patient of Dr. C. A. Porter.

History.—Patient had previously entered the hospital on October 30, complaining of dull pain in the right hypochondrium for the past seven years, and chronic constipation. A year ago, he was seized with sharp pain in the epigastrium, which later localized itself in the right iliac fossa. The pain was constant and very severe. No vomiting, no chill; had never been jaundiced. Examination at that time showed the abdomen to be tender, especially in the region of the gall-bladder, where there was some rigidity. Under rest in bed, in five days the patient was discharged relieved, to report again.

From November 5 until re-entry on February 17, patient had had several attacks of severe pain in the upper abdomen and right hypochondrium. A month ago he had slight jaundice, and a diagnosis of gall-stones was made. On February 15 patient suffered from a sudden and severe abdominal pain in the epigastrium

and right iliac fossa, was nauseated, but did not vomit. Morphine gave relief. Pain continued, and has steadily increased; is now general throughout the abdomen, somewhat more marked in the right hypochondrium and flank. Last night patient began to vomit, and this has become continuous. Bowels moved once after an enema.

Examination showed a somewhat emaciated man, evidently in great pain and distress. Skin was moist, slight dyspncea. Patient is vomiting continuously, thrashing about in the bed. Vomitus, brown, sour-smelling, not faecal, no blood. Abdomen moderately distended. Greatest pain referred to the right costal border and epigastrium, next to the right iliac fossa. No visible peristalsis. Rigidity moderate. Less marked in the epigastrium and the right iliac fossa. Deep pressure in the latter region causes pain and increased rigidity. Examination of epigastrium impossible, owing to rigidity. Abdomen tympanitic in centre, flat in both flanks, dulness shifts readily, therefore free fluid is present. Temperature, 100° F.; pulse, 100, of poor quality; respiration, 30; leucocytosis, 8000. At the time, a diagnosis was made of probable intestinal obstruction from a band in connection with an old inflammatory process about the gall-bladder or appendix.

Ether was given, and a median incision from three inches below the ensiform cartilage to two inches above the pubis, through the right rectus muscle. On opening the abdominal cavity, large amounts of brownish, red fluid emerged. This fluid was clear, and evidently colored by blood. Culture made reported sterile. The intestines were everywhere injected. No tumor or band could be found, and no especially distended coils of intestine. Examination of the appendix showed that it was large and injected, but not gangrenous. Disseminated throughout the abdomen were numerous areas of fat necrosis, which varied in size from a pinhead to a split pea. The fat necrosis in the meso-appendix was especially well marked. The appendix was removed.

Examination of the gall-bladder showed a few adhesions, and that it was slightly distended with bile. Examination of the pancreas showed it to be enlarged to three times its normal size, very hard and tense. After thorough irrigation of the abdomen with salt solution, the median incision was closed, and an incision along the left costal margin, five inches long, made. With deep re-tractors the ribs were held upward, the small intestines and stom-

ach were packed with gauze upward, and towards the median line. Examination of the pancreas was made through the mesentery of the transverse colon. From the spleen to the duodenum the pancreas was very large, tense, and oedematous, of a deep purplish color. No stones could be felt in the duct. It seemed evident that the diagnosis of acute pancreatitis required proper drainage, therefore an incision was made through the mesentery from the median line to the tail of the pancreas. This incision was about four inches long and three-quarters of an inch deep. Several areas of fat necrosis were found in the peripancreatic tissue. A rubber tube was placed up to the pancreas, and all of the intestines were carefully walled off with gauze sponges.

Recovery after operation was rapid. Vomiting stopped, the patient had far less pain, there was no fever, no increase in the white count, and the pulse soon fell to 80. At the end of a week the gauze was changed, and the wound appeared healthy. On the twelfth day, two small pieces of gangrenous fat tissue came away. The gauze was changed three times a week, and the wound rapidly granulated and healed. Throughout the convalescence, the leucocytosis never rose above 10,000. There was no distention, the bowels moved normally.

Urinary examination showed interesting conditions. Immediately after the operation, a slight trace of albumen, with granular casts. On the 23d of February, bile in large amount, few casts, also 1.4 per cent. of sugar. On the 26th, sugar was absent, albumose present in small amount. By March 2, the urine was normal, except for an increase of indoxyl and kreatinin. Numerous experiments were made with salol, feeding with a large amount of grape sugar, etc., and investigation of the stools for undigested fat. All of these tests showed nothing abnormal.

On April 1, the patient was up and about, and had gained much in color and general health. Convalescence seemed perfect.

About the middle of April, however, he complained from time to time of pain in the epigastrium, above the umbilicus. There was no fever, no increase in leucocytosis. The bowels had not been acting very well.

In view of the persistence of this pain, it seemed wise on April 17 to operate again, in order to find out whether a stone were impacted in the common duct, and if none were found, it was planned to drain the gall-bladder. On April 17, a five-inch

incision was made along the outer border of the rectus muscle, from the rib margin downward. On opening the cavity, adhesions were discovered between the omentum and the anterior abdominal wall. The gall-bladder was found to be much thickened, but not distended. Numerous adhesions about it showed evidence of an old inflammation. The duodenum was separated from behind; with one finger in the foramen of Winslow and another behind the duodenum, the whole biliary passages were examined. No stones could be felt, but the common, cystic duct, and gall-bladder were markedly thickened. The pancreas had again resumed its normal size and feel, except in the head, where some induration was present. No evidences of fat necrosis had remained behind. Finally, it seemed best to make a small incision by tearing between the stomach and the transverse colon. With one finger in the lesser peritoneal cavity, and the others behind the duodenum and pancreas, careful palpation revealed a slightly fluctuating area in the head of the pancreas, about two centimetres in diameter. This was incised through the lesser peritoneal cavity, and a teaspoonful of broken-down débris evacuated. Cultures from this were sterile. A finger-tip placed in the cavity could feel no stone. This cavity was curetted clean and packed with gauze. The gall-bladder was sewed to the anterior abdominal wall, but not opened. A wick was inserted under it to drain the space rooted up by the freeing of the duodenum.

Convalescence from this operation was complicated by pneumonia in the right base, with much foul, purulent sputum. The temperature rose to 103° F., but fell to normal six days after operation, from which time convalescence has been uninterrupted. On May 20, the patient was discharged with a very small sinus in the wound. Owing to freedom from pain, the gall-bladder has never been opened. No sugar or abnormal urine constituents could be found after the second operation. Patient has gained ten pounds in weight.

A REVIEW OF THREE HUNDRED AND THREE OPERATIONS UPON THE STOMACH AND FIRST PORTION OF THE DUODENUM.¹

WITH TABULATED REPORT OF THREE HUNDRED AND THIRTEEN OPERATED CASES.

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FUNCTIONALLY the small bowel begins at the entrance of the common duct of the liver and pancreas, which about marks the primitive division between the foregut and the midgut (Huntington). The first portion of the duodenum may be said to be the vestibule of the intestinal tract, and its diseases partake more of the character of those of the stomach rather than the intestine. In the large majority of instances, lesions at this point cannot be diagnosticated accurately from similar diseases in the stomach, and are usually due to the same causes. For this reason I have associated all of the cases of this description into a single group for the purpose of study. Total number of cases, 303. Of these 286 are taken from the records of St. Mary's Hospital, Rochester, Minnesota, and the remainder are from the records of the Minnesota State Hospital for the Insane at Rochester and St. Peter. The average age was forty-two; males, 42 per cent.; females, 58 per cent.

Duodenum, twenty-six cases, two deaths, 7.6 per cent. Lesions of the first portion of the duodenum can be divided into two groups; first, those due to ulcer, and, second, those associated with gall-bladder disease.

Ulcer limited to the duodenum was found eleven times,—one acute perforating, two chronic perforating protected by adhesions, five active, and three cicatricial contraction with obstructive symptoms. Two died after operation,—one from pneumonia following excision of the ulcer, one from exhaustion

¹ Read before the Philadelphia Academy of Surgery, May 11, 1903.

after gastro-enterostomy. In three cases, the signs and symptoms were not to be distinguished from gall-stone disease, and the operation was undertaken under the supposition that the trouble was in the gall-bladder. Five times ulcers existed upon both the duodenum and stomach. Of the sixteen cases in this group, fourteen were in males. The duodenum was frequently associated with gall-stone disease, and usually secondary to it; but in eleven cases the duodenum was the prominent feature. Five were due to gall-stone perforation, requiring intestinal suture. In three of these the gall-bladder was completely separated functionally from the bile-tract, and had become an appendage to the duodenum. Four times, crippling adhesions to the gall-bladder, but without stones or evidence of cholecystitis, were encountered, requiring dissection to loosen,—a periduodenitis of unknown origin. In one case an inflammation of an accessory lobe of the pancreas was the cause of dense adhesions. All but one of the cases in which the gall-bladder was involved occurred in females. There were no deaths in this group. In no instance was the duodenum the seat of primary malignant disease, and in but two cases was there any evidence of extension from pyloric cancer, and then it was not marked. In two patients the diagnosis of lesions originating in the duodenum was made previous to operation. The differentiating features of these cases were, good appetite, delayed pain, general absence of vomiting, and in only one case, and that on one occasion, was there haematemesis. In two cases there was evidence of blood in the stool. Otherwise the signs and symptoms were similar to lesions of the stomach or gall-bladder, and, even in the light of operative investigation, points of differentiation did not become evident. Our experience leads us to believe that surgical diseases of the duodenum are much more frequent than has been thought.

The subject of perforating and bleeding ulcers of the stomach has been so thoroughly dealt with by Keen and Foot, Weir, Robson, Rodman, and Andrews, and lesions of a similar character in the duodenum by Weir and Murphy, that it seems unnecessary to dwell upon the few cases which have occurred

in this series, and for further information, the classified table appended may be examined at leisure. In the present communication I will discuss briefly the results obtained and some practical deductions based upon two large classes of cases. First, Gastric ulcer and associated causes of serious disturbance. Second, Cancer of the stomach.

Stomach, 277 cases, twenty-eight deaths, 10.1 per cent. In the benign group there are 168 operated cases with eleven deaths (6.5 per cent.), and nearly all of these operations were for chronic ulcer and its late cicatricial results. Included in this class are all of the non-malignant obstructions. The conditions calling for operation were gastric pain with or without acute exacerbations, repeated haemorrhages, emaciation from inability to retain sufficient nourishment. In a few cases, dilatation due to known or unknown cause gave mechanical reasons for interference.

Without going into the controversy as to the causation of gastric ulcer, there is no doubt that perverted stomach secretion is the most important manifestation in the majority of cases. This is shown by the almost constant association of excessive secretion in ulcer, and the fact that similar ulcers in the duodenum are in that part of the intestine not protected by the alkaline juices poured in through the common duct. In this connection, most interesting information is furnished by those reported cases in which a typical peptic ulcer has developed in the jejunum immediately below a gastrojejunostomy made for the purpose of drainage, the lesion in the jejunum in every particular resembling the original ulcer for which the gastro-enterostomy was performed. In operating upon cases of this description, the excessive amount of gastric secretion is constantly in evidence, and the results of drainage operations in relieving the distress and healing the ulcer bear out the importance of this view of the case.

Attempts to classify ulcers of the stomach have been based largely upon post-mortem experience and accidental complications, such as perforation and haemorrhage. Such classifications tend to exaggerate the importance of fatal complications,

which render surgery a desperate resource rather than a well planned effort at cure.

Further surgical observations are necessary to clarify the confusion which surrounds gastric ulcer. In attempting to group our operated cases, we found that there were such wide variations in the conditions present that no orderly classification could be made on a purely clinical basis. In a general way, the following answered the purpose most satisfactorily:

1. Round and fissure ulcers; (*a*) acute, (*b*) chronic. They have the distinguishing feature that there is but little thickening about the base of the ulcer. Many amount to little more than a fissure, and are closely associated with group 2.
2. Mucous erosions; a condition which must be accepted with caution.
3. Chronic ulcer with a thickened base and usually irregular in form, probably an extensive variety of the chronic round ulcer.
4. Benign obstructions without regard to cause, although usually of inflammatory origin.

In our experience at the operating table, it is the last two varieties which are most frequently met with. The acute round ulcer of Cruveilhier occurs by preference in the chlorotic type of adolescent females and usually responds to medical treatment. Operation is most often called for in the acute cases by that peculiar perforation so graphically portrayed by Rokitansky, "cut out by a punch;" or by severe haemorrhage from the stomach. Chronic round ulcer and fissure ulcer do not often lead to harmful cicatricial contraction on account of their small size. Near the pylorus they may be the starting-point for a band-like stenosis encircling the pyloric ring. Chronic round ulcer is usually found in adults, and in our experience has been more frequent in females. It would seem that there is little difference between the chronic round ulcer and the chronic cicatricial ulcer, excepting that as the outer coats are involved the extent of ulceration increases and loses its characteristic round or oval form, while usually a healing process is apparent in some part of its extent. A subvariety of

this group is the "pore-like" ulcer described by Murchison, which is met with more often in adults and gives rise to grave haemorrhages, and yet is so minute that it is difficult to locate, even at post-mortem. The mucous "erosion," limited to a small area or several such patches, was seen in a few instances. The large "mucous erosion" described by Dieulafoy as giving rise to alarming haemorrhages was not met with. I am unable to say just how much importance is to be attached to the surface erosion of limited extent. In the first place, the detection is difficult. The whole question of the surgical exploration for round ulcers and erosions is one surrounded with difficulty and uncertainty. There are usually no external manifestations which lead to location of the lesion, and the only way a diagnosis can be established is to open the stomach and with a short, wide speculum explore the interior. The margin of the instrument may and frequently does produce a traumatism to the superficial mucous layers, and the result is very like the pathological erosion. We have seen undoubted and typical examples covered with a membranous film of mucous character which, when brushed off, allows the nature of the trouble to become apparent. The chief obstacle to accurate diagnosis lies in the surgical indications which are to be met. Round ulcers and erosions are often multiple, and, as a rule, do not cause cicatricial contraction at the pylorus. Clinical experience has demonstrated that drainage is the best method of surgical treatment with which we are acquainted, therefore an exploration, however attractive to the surgeon, is often not completed; but the surgical indications are fulfilled by some form of gastrointestinal operation and the diagnosis remains unproved. The surgeon hesitates to expose the patient to even a slight risk for purely diagnostic purpose. The old adage, "a good prognosis is better than a good diagnosis," leads to operations based upon symptoms. If round ulcer is found, excision is the proper course; but there is always the chance that the ulcer excised is not the only one, and that others may exist undetected or in an inaccessible situation.

We may well ask ourselves in such cases, Does an ulcer

exist? and usually we may answer yes, and base the diagnosis upon such symptoms as would establish a medical diagnosis. Clinically, these cases come to us after medical treatment has failed utterly, and either the diagnosis is unquestioned or there is secondary interference with motility, resulting in retardation or retention and gastric dilatation, giving mechanical reasons for interference. The theory of pyloric spasm is most interesting, and is a hypothesis rather than a definite condition. I have examined the pylorus in over 300 cases at the operating table with a view of establishing a normal under anæsthesia. Usually, the normal pylorus in the anæsthetized patient will allow the thumb and the forefinger to nicely meet, about the caliber of a silver dime, and under some conditions of deep anæsthesia it may be found dilated to the diameter of a silver twenty-five-cent piece. I am satisfied, however, that spasm of the whole or some part of the pyloric portion of the stomach may and often does take place, and that it is one of the causes of the retention of the excessive secretions and distress; but I am by no means sure that it is confined to the pyloric sphincter.

The so-called "chronic ulcer" of Robson has a thickened base and is frequently of large size and irregular outline, in this respect differing from the chronic round and fissure ulcer, in which there is but little new tissue deposit about the ulcer. Does the round ulcer lead to the chronic cicatricial ulcer? It is probable that the difference is merely one of degree, although the fact that the latter is much more common in males is rather against this theory.

The majority of operations were for thick-based chronic ulcer of the stomach or its late results, and these cases were very satisfactory, the irregular thickened patch of stomach or duodenal wall often locating the process with exactitude. As a rule, the ulcer was located near the lesser curvature and not infrequently at the pylorus. The posterior wall was affected more often than the anterior, if only one surface was involved. On the duodenum the anterior wall was most often the seat of ulceration. The youngest patient was a girl of seventeen and the oldest a man of sixty-four. In 60 per cent. of our malig-

nant cases, a previous history of ulcer was obtained. In two cases, malignant degeneration of the margin of a chronic gastric ulcer was demonstrated; certainly a strong argument for the excision of such ulcers when possible. We found conditions favorable for excision of ulcer in only three cases. On six occasions we either excised or turned an ulcer in by suture, in combination with pyloroplasty or gastroduodenostomy. In two of these cases, three-fourths of the pylorus was excised and closed by suture.

Lund has pointed out that "sentinel" enlarged lymph nodes in either the lesser or greater omenta may aid the surgeon in locating the ulcer. We have found this a valuable observation.

In all of the ulcers of every description which we examined, the upper two inches of the duodenum, pylorus, pyloric antrum, and that part of the stomach lying to the right of a line drawn downward from the œsophagus was the seat of disease, and in only a few instances of extensive hour-glass contraction did the ulcer extend to the left of this line. In handling the stomach during operation, limited contraction of the wall could often be noticed in the pyloric third, but not towards the cardiac end. Cannon's experiments are very interesting in this respect. He demonstrated with bismuth and the X-ray that the fundus of the stomach did not contract strongly, but that the pyloric portion, by a backward action, kept up a current in the fundus. Ulcers occur in all parts of the stomach; but in the cardiac end it is a question if they are often the cause of chronic symptoms calling for operation.

Twelve chronic dilatations without ulcer or obstruction were operated upon. In all of the cases, the stomach wall was of normal or increased thickness, indicating that an obstruction, either from a high-lying but non-stenosed pylorus, or beyond the pylorus, existed. In 1895 I reported several cases of interference with free gastric drainage by "valve formation," due to a short gastrohepatic omentum holding the pylorus high, the body of the stomach sagging sharply downward. More than half were of this description. In a few instances the medical

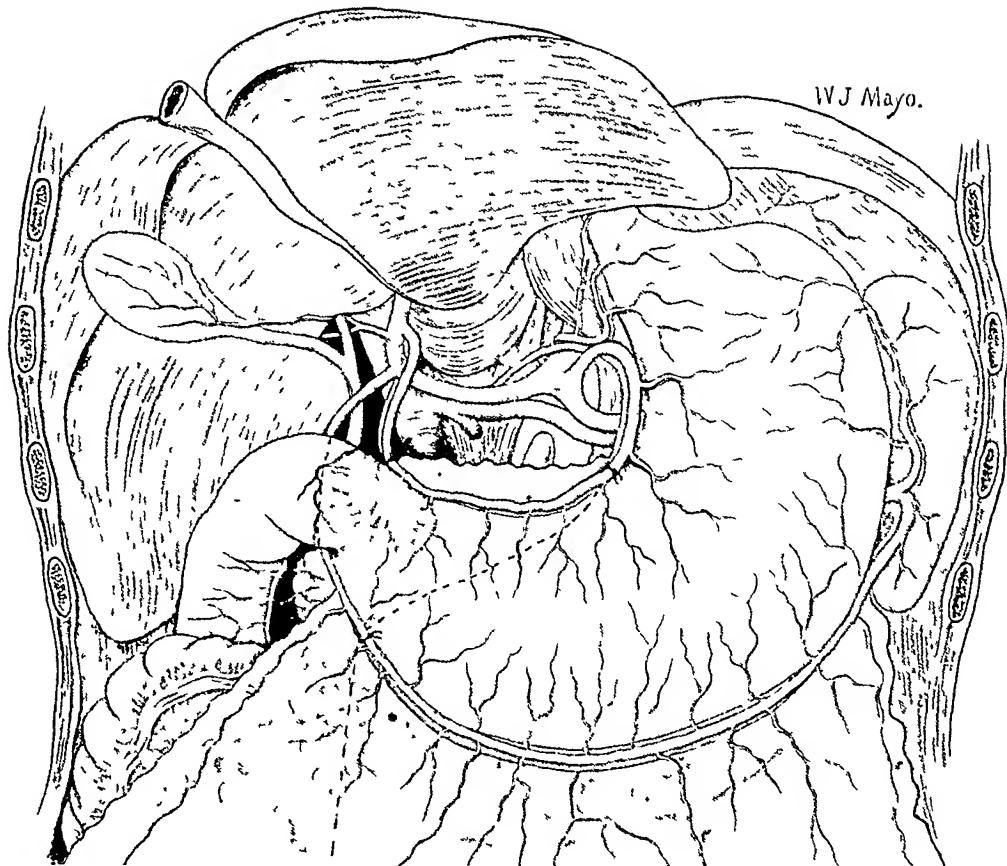


FIG. 1.—Showing line for incision in cases of ulcer of the stomach.

diagnosis was extreme atonic dilatation; but even in these cases there was no great thinning of the gastric wall. We have not considered simple gastrophtosis sufficient cause for operation, but in a few cases exploration revealed this condition, and in all the stomach wall was either of normal thickness or thinner than normal. In three of these cases, shortening of the gastrohepatic ligament after the method of Beyea was done.

Cancer of the stomach, 109 cases, seventeen deaths, 15.6 per cent. Late diagnosis and cachexia make the aspect of this group discouraging. Palliative operations predominate with considerable immediate mortality and no great prolongation of life. The hope of the future lies in early exploratory incision, and the necessity for this depends upon clinical observation rather than laboratory methods, which too often only become valuable when the extent of the disease is beyond cure. Given a patient of middle or later life who begins to lose flesh and appetite and suffer from indigestion without apparent cause, the possibility of cancer should be considered; and if the source of the symptoms cannot be shown within a few weeks, the situation should be explained to the patient, and the choice between exploration and procrastination allowed him. When we consider that early operation is the only hope, we may not wait on our own responsibility. The public in this way will soon become educated and cures will be more frequent. Gastrojejunostomy for malignant disease, in our hands, has had an increasing mortality, due to the fact that the better cases are selected for gastrectomy, and the late hopeless obstructions are given the meagre benefits of gastro-enterostomy, thirty-four cases, ten deaths, 30 per cent.

Is there an outlook for cancer of the stomach? We know of the prime necessity for early operation; it now remains to demonstrate how the procedure can be made more effective. In a general way, the lymphatics of the stomach lie in three groups; first, the lesser curvature and lesser omentum; second, along the greater curvature and the gastrocolic omentum; third, in the gastrosplenic omentum. The main lymphatic channels follow the direction of the blood-vessels to the deep glands about the coeliac axis. The dome of the stomach, as

pointed out by Robson, has no main lymphatic channels and few lymphatic glands. If all of the stomach excepting this portion be excised, the remaining part will be adequately nourished on the right side by cardiac branches derived from the gastric artery which joins the stomach at a point from one to one and one-half inches below the œsophagus. On the left, the *vasa brevia* given off from the splenic artery distal to the origin of left gastro-epiploic vessel, a distance of four and one-half to eight inches from the œsophagus, give an adequate blood-supply. These vessels anastomose with the inferior phrenic vessels. Therefore, excision of all the stomach lying below and to the right of a line drawn between the gastric artery and the left gastro-epiploic vessel is the logical operation. The advantage of this line of section is obvious. All of the main lymphatic connections are removed at the primary operation. The remaining portion of the stomach we know clinically is seldom involved unless the primary lesion is at the cardiac orifice, and the retention of the dome of the stomach enables comparatively easy intestinal anastomosis. One reason that only from 5 to 8 per cent. of gastric cancers have been cured by extirpation lies in the fact that a part of the organ has been retained in which the vascular and lymphatic connections with the diseased area have not only been close but direct. In the dome of the stomach, the lymph current is feeble through small vessels, and, most important of all, is in the other direction. Mikulicz has already called attention to the necessity of removing the whole of the lesser curvature with its gastrohepatic omentum, and has done much to elucidate the question of lymphatic infection by showing that in twenty cases of gastric cancer only one was completely free from lymphatic involvement, although, in a total of 189 glands examined, 110 were found to be without contamination. In making this radical operation we have proceeded as follows:

First, ligate the gastrohepatic omentum from the pylorus to the gastric artery, which is tied. The section is made as close to the liver as possible, and includes nearly the whole of the lesser omentum. This mobilizes the pyloric end of the stomach, which is drawn down and out. Second, with the

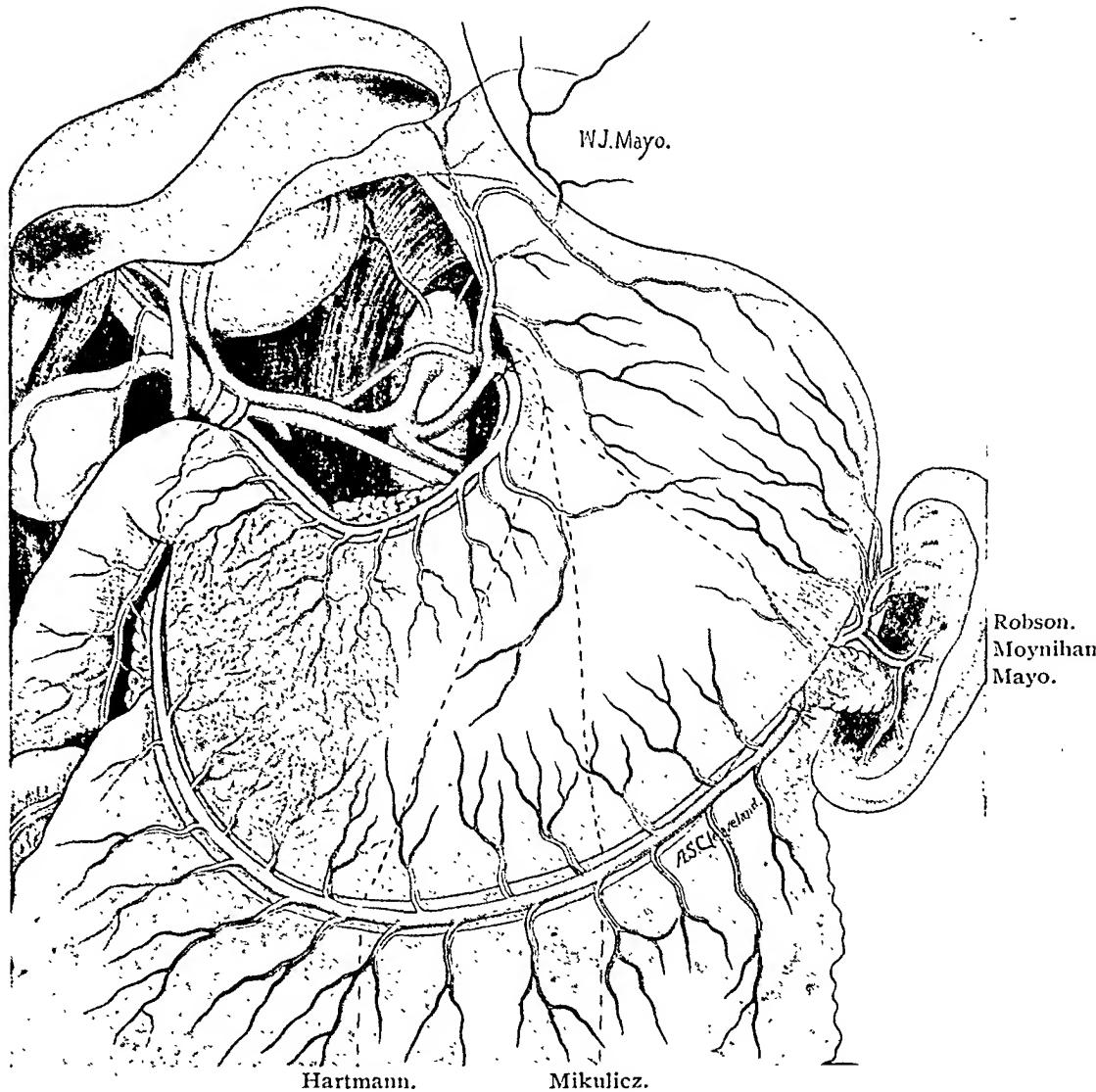


FIG. 2.—Lines of incision practised by different surgeons in the removal of cancer of the stomach.

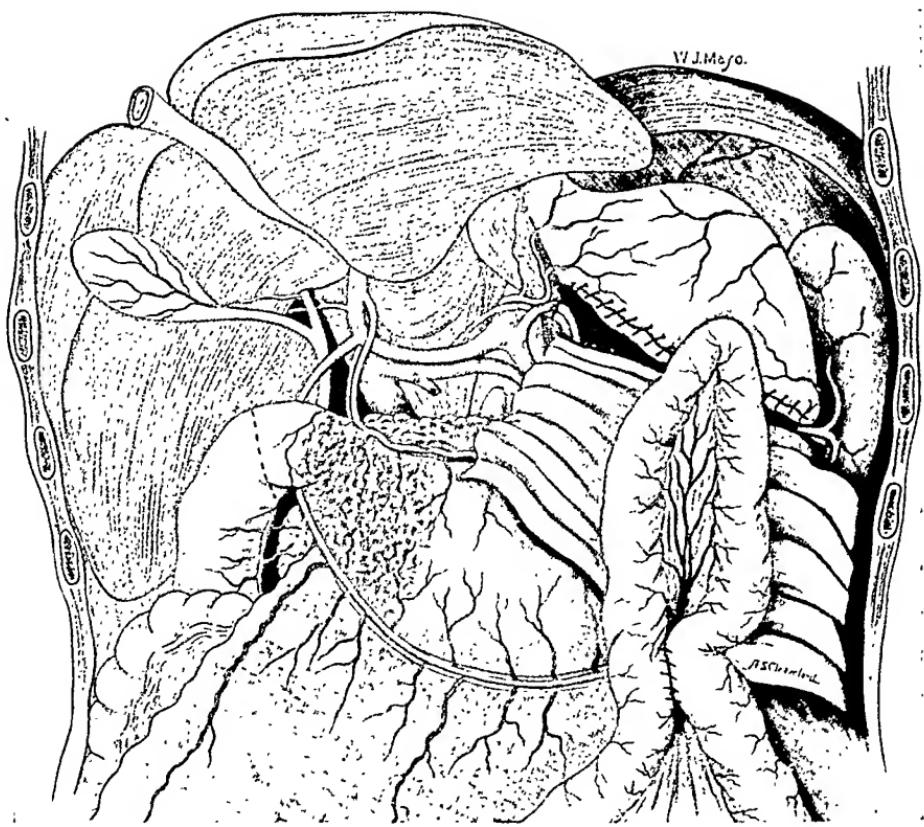


FIG. 3.—The completed operation for cancer of the stomach.

fingers in the lesser cavity of the peritoneum, the gastrocolic omentum is ligated at a safe distance. The duodenum, on the one side, and the pylorus, on the other, are doubly clamped and divided between with the cautery knife. A purse-string suture of silk is placed around the duodenum three-fourths of an inch below the divided end, and, after suturing with catgut through the cauterized area, the stump is inverted and the purse-string suture drawn tight. This disposes of the duodenum permanently. Third, ligation of the gastrocolic omentum to a point near the origin of the left gastro-epiploic artery, which is tied. Fourth, a groove is made by heavy pressure forceps, separating the dome from the balance of the stomach and with catgut on two needles, a shoemaker stitch in the pressure furrow renders section with the actual cautery bloodless and avoids opening the portion of the stomach to be retained. This line of suture is turned in by a continuous silk Cushing suture supported occasionally by an independent Halsted stitch of the same material. In this step of the operation we sometimes use the Kocher clamp and suture each layer separately. Fifth, gastrojejunostomy between the gastric pouch, which is just about large enough for the purpose, and the jejunum. Sixth, entero-anastomosis between the two limbs of jejunum, short circuiting the biliary and pancreatic secretions as nearly as possible at the same level as the origin of the jejunum. It took two deaths to teach us the value of this manœuvre. The deaths were not from regurgitant vomiting; but when the anastomosis was affected in some cases, the intestine was sharply bent at the site of union, being drawn upward and to the left in such a manner as to leave from fourteen to sixteen inches of jejunum hanging upon the anastomosed area, a situation in which peristalsis does not materially aid in onward flow of the biliary and pancreatic secretions. The proximal loop becomes distended with these juices to the level of the anastomosis, giving a traction weight of a column of fluid the diameter of the distended intestine. In one patient on the fifth and in one on the ninth day union suddenly gave way entirely, or in part, in patients apparently doing well. This does not happen in every case,—two out of

eight only; but in at least half of the cases the bad mechanics of the situation was evident on inspection. Seventh, the remains of the gastrocolic omentum are attached to the posterior wall and the abdomen closed. This operation should give all the benefits of complete gastrectomy in pyloric cancer. (I find that Mr. Moynihan, of Leeds, has recommended and practised a similar procedure, but his work was buried in the Clinical Society of London, which does not permit of journal publication. I did not know of it until he informed me personally during his visit in May, 1903.)

In view of the splendid work of Hartman and Cuneo, it is a question whether the operation outlined should be the routine one, or for exceptional cases only. That the whole of the lesser curvature with the glands in the corresponding portion of the lesser omentum should be removed is the conclusion of all of large experience; but the advantage of removing the major part of the greater curvature is open to debate. Cuneo demonstrated that the lymph current along the greater curvature was from the left to the right, and that in pyloric cancer not only is there comparatively little tendency to lymphatic involvement in this region, but that it is confined to the glands in the immediate vicinity of the growth, and does not extend to the left of the pyloric portion. Hartman therefore bases his line of section upon this fact, and removes all of the lesser curvature and saves as much as possible of the greater curvature. We have several times made an operation very similar to that described by Hartman, as it is certainly much easier than the one which we have outlined, and, as the mechanics of the anastomosis is better, entero-anastomosis is unnecessary. Occasionally, however, growths or glands are found to the left along the greater curvature. It may be said that such cases are inoperable, yet we have had two such patients live beyond a year. In the eight cases operated upon by the radical method given above, there were three deaths, while there were but two deaths in the eighteen remaining cases operated by various methods from simple pylorectomy to the operation of Hartman. The former group comprises only a small number of the worst cases,

and some of the deaths were avoidable by a better technique. Be this as it may, some form of radical extirpation has been the only reasonably satisfactory operation we have performed for cancer of the stomach, twenty-seven cases, five deaths, 18.5 per cent. (Since completing this paper, one case died after five weeks from abscess of the lung, making six deaths, 22.5 per cent.) One patient lived three years and seven months before recurrence. Several are alive and well over two years, and the general average has been over a year. It is surprising how few of those recovering from the operation have failed to live a year or more.

It may not be out of place to briefly discuss the merits of the three chief methods of improving stomach drainage, namely, pyloroplasty, gastro-enterostomy, and gastroduodenostomy.

Nineteen cases were subjected to the pyloroplasty of Heinicke-Mikulicz; six of these came to secondary gastrojejunostomy through failure of the operation to adequately drain the stomach. The remaining cases are well. There were no deaths. The opening can be made of sufficient size, but the increase in caliber is not in the line of gravity drainage, or, at least, the enlargement of the opening is as much above the pylorus as below it, and the greatly dilated stomach with its overstretched and degenerated musculature is unable to elevate the food, and the stagnation is not entirely relieved. Again, in the six reoperated cases, the pylorus was found adherent at a high level, due to the abstinence of food and other causes of downward traction during the healing process. In three cases we fastened the pylorus, after plastic operation, to the neighborhood of the umbilicus by suture, to secure a low point. These patients have remained well; but as we were also careful to choose only moderate dilatations, the value of the manœuvre is uncertain, and there are objections to the plan.

Gastro-enterostomy was done 168 times, divided as follows: Gastrojejunostomy, 121; gastroduodenostomy after Finney, twenty-six; independent gastrojejunostomies in connection with pylorectomy and gastrectomy, twenty-two. Of

the 121 cases of gastrojejunostomy made purely for drainage purposes, there were seventeen deaths. The percentage of mortality in the benign cases was 8 per cent., in the malignant, 30 per cent.; the great mortality of the latter being due to the choice of favorable cases for radical operation, the hopelessly advanced and cachectic coming to gastro-enterostomy, and, could the condition have been known beforehand, an operation would not have been undertaken in some of these cases.

Gastrojejunostomy for benign obstruction at the pylorus is one of the most satisfactory operations with which we are acquainted. It rapidly drains from the lowest point, and if the obstruction at the pylorus is permanent, the new opening does not contract materially. Again, if the opening be made at the bottom of the stomach-pouch at or near the greater curvature, regurgitant vomiting will not take place and entero-anastomosis is unnecessary, providing either the Murphy button or Robson bone bobbin be used to mechanically maintain an opening during the early critical period. We can only speak from these two methods, as we have had no experience with any other plans. In some instances a feeling of distention or vomiting after operation may take place, and, under such circumstances, we promptly direct gentle stomach lavage. We now use the posterior suture operation over the bone bobbin for benign obstructions and the Murphy button for malignant disease, and in the latter instance the anterior method. However, as between the suture and the Murphy button and the anterior and posterior operation we have been unable to see any marked difference in results beyond the occasional retention of the button in the stomach, which seems to be of no practical importance.

During the recent visit of Professor Mikulicz to this country (May, 1903), he had the kindness to do a posterior gastro-enterostomy in our clinic by a method which I believe is greatly superior to the one we had been in the habit of doing. It avoids the possibility of angulation, as it does not form a loop with its attendant dangers. The operation as performed depends on two simple principles. First, the origin of the jejunum lies above the greater curvature of the stomach.

After opening the transverse mesocolon and fastening it to the posterior wall of the stomach, the upper three or four inches of the jejunum lie directly in contact with the gastric wall, hanging perpendicularly with its free border (opposite the mesentery) facing the stomach wall. Second, by making a transverse incision in the jejunum three or four inches from its origin and an incision close to the greater curvature of the stomach, a suture anastomosis is made in which the stomach is drained at the lowest point without the possibility of kinking the intestine. The whole trouble has been that in making a longitudinal incision in the intestine it was necessary to form the misfortune-breeding loop. The scheme of the operation is much the same as used by Czerny. The good mechanics of the procedure has been especially dwelt upon by Peterson of the Heidelberg Clinic.

Gastrojejunostomy, if the pylorus be unobstructed, is far from satisfactory. In a paper read before the American Surgical Association, June, 1902, I reported four cases in which contraction at the site of the anastomosis took place, and we have reoperated upon four similar cases since that time. In six of these cases we did a secondary entero-anastomosis between the limbs of the loop. Four times the entero-anastomosis was effected with the Murphy button, and two of these patients died from sudden separation of the anastomosed area at the end of the first week. This did not take place in two suture operations. In all of these cases the proximal limb of jejunum from the point of anastomosis to its origin looked enlarged and thickened, a condition that might be called water-logged and in marked contrast to the bowel immediately distal to the anastomosis. In this condition of the afferent loop lay the reason for the failure of the plastic union after the button, and merely illustrates the well-known danger of setting up pressure necrosis in damaged tissues. Primary entero-anastomosis with the button is safe, but not so secondary operations. If the obstruction at the pylorus is complete, this condition of the jejunum above the gastro-intestinal anastomosis has not been found. A large number of cases of benign affections of

the stomach without pyloric stenosis require operation. This is particularly true in ulcer, and relapse after this operation has been frequent. Our observations would seem to show the following course of events. After the operation there is at least temporary healing of the ulcer. The pylorus begins to functionate normally and the unnecessary gastro-intestinal fistula contracts. There is renewed irritation from retained secretions, followed by reopening of the ulcer, return of pyloric spasm, and failure of the operation to effect a permanent cure. In some cases the double stomach drainage seems to give rise to unpleasant symptoms without contraction of the fistula. In twenty-eight cases of gastrojejunostomy with open pylorus, eight came to secondary operation from contraction of the gastro-intestinal opening, while in all cases with permanent obstruction at the pylorus there were no cases of secondary operation from this cause. This has also been the experience of Ochsner, who also points out the fact that if relapse takes place, symptoms will arise within four months. To obviate this sequela, in one case, at the primary operation, we divided the pylorus and closed both the gastric and duodenal ends by suture, thus creating the favorable condition of complete obstruction. Once we sutured the pylorus high up under the liver, causing valve formation, as first suggested by Cordier. Once we placed a circular purse-string suture about the pylorus, closing sufficiently tight to obstruct the opening. This idea was adopted from Dawbarn. I may say that all of the methods proved satisfactory; but there was the grave objection of too much operating for a benign condition, and it introduced unnecessary elements of danger. In June, 1902, Dr. Finney introduced his method of so-called pyloroplasty, but which is in reality a gastroduodenostomy. The opening is downward in the line of gravity, and in most of the suitable cases for this operation the gastric dilatation is not extreme. In two cases of rather extensive dilatation and pouching we combined with it shortening of the gastrohepatic ligament as described by Beyea. The operation of Finney is especially adapted to those cases in which there is little disease about the

pylorus. It enables careful examination of the pyloric end of the stomach, and excision of a neighboring ulcer can be easily combined with it. We had two such cases. It is less suitable if there be extensive involvement of the pylorus; but it is in just this class of cases that gastrojejunostomy is at its best. The question to be settled by further experience is, whether the operation of Finney will as rapidly cure active ulcer of the stomach as gastrojejunostomy. In the latter operation the drainage is from the cardiac end to the left of the muscular pyloric portion; while, even if the pylorus be made of ample size by the Finney procedure, the food and secretions must pass the ulcer site before it leaves the stomach, and we know that obstruction is not all necessary to the formation of ulcer, as they exist beyond the pylorus in the duodenum. In twenty-six cases operated upon by the method of Finney, we had one death, and that from avoidable cause. Were it not for the mortality, resection of the muscular pyloric portion of the stomach would be indicated in gastric ulcer, as in this way the ulcer-bearing area would be permanently disposed of and an absolute cure insured. This was first suggested by Rodman, and I believe with him that this will be the operation of the near future.

A TABLE OF 313 OPERATIONS UPON THE STOMACH AND FIRST PORTION OF THE DUODENUM.

BENIGN.	STOMACH.		
	Total.	Recovered.	Died.
Gastrojejunostomy.....	89	82	7
Gastroduodenostomy.....	28	27	1
Pyloroplasty	19	19	..
Gastrostomy.....	4	4	..
Gastrotomy.....	5	5	..
Excision of ulcer.....	3	3	..
Perforating ulcer.....	2	1	1
Gunshot.....	1	1	..
Gastrorrhaphy.....	1	1	..
Gastroplication	1	1	..
Hour-glass stomach	3	2	1
Adhesions.....	8	8	..
Shortening of gastrohepatic ligament (Beyea). .	6	..	..
Subdiaphragmatic abscess from gastric ulcer..	2	1	1
Fistula of stomach and gall-bladder	1	1	..
	<hr/> 173	<hr/> 156	<hr/> 11

CANCER.

	Total.	Recovered.	Died.
Gastrectomy and pylorectomy.....	27	22	6
Gastro-enterostomy	34	24	10
Gastrostomy.....	13	11	2
Exploratory	38	38	..
	<hr/> 112	<hr/> 95	<hr/> 18

FIRST PORTION OF DUODENUM.

	Total.	Recovered.	Died.
Excision of ulcer	3	2	1
Perforating, acute.....	1	1	..
Perforating, chronic.....	2	2	..
Chronic ulcer.....	6	5	1
Ulcer of both duodenum and stomach.....	5	5	..
Anastomosis between the first and second portion of duodenum for ulcer	1	1	..
Adhesions, result of periduodenitis.....	4	4	..
Adhesions, result of inflammation of accessory lobe of pancreas.....	1	1	..
Fistula between gall-bladder and duodenum requiring suture.....	5	5	..
	<hr/> 28	<hr/> 26	<hr/> 2

AN IMPROVED FILIGREE FOR THE REPAIR OF LARGE DEFECTS IN THE ABDOMINAL WALL.¹

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THE problem which confronts the surgeon in the removal of a large tumor involving the abdominal wall is not how to get it out, but what to do afterwards towards a repair of the damage. If a large section has been cut away, and the operator would completely restore the integrity of the barriers to herniation of abdominal viscera, then he must devise for his patient something which will give greater security than that afforded by the various autoplasty measures of the past. The need of an artificial aid for reinforcing the belly wall has been felt, too, in those cases where an extensive hernia has resulted from the stretching of a scar or from the thinning which is produced when an improperly directed incision disturbs nerve supply and causes muscles to atrophy. Further, the incorporation of foreign substances into the tissues has not been despised even in the treatment of ordinary inguinal and femoral hernia, though it is not my purpose in this article to deal extensively with these two last-named conditions. A large umbilical hernia is, on the other hand, a very different matter, and has surely been regarded as a sort of *bête noir* of surgery by many.

A serious consideration of prophylactic and remedial measures in large herniæ, of whatever nature, is surely justified by the knowledge that the individual thus afflicted can be nothing but a miserable invalid. Not even the best fitting supporter can render life more than bearable, nor is it possible for such a person to make any severe exertion, whether it be in the pursuance of an occupation or in the enjoyment of an athletic sport. None

¹ Read before the Missouri State Medical Association, April 22, 1903.

of the autoplasty operations offers a guarantee of success in the treatment of these cases, provided the lesion be extensive, and unfortunately all tend to become so as time passes. It was not until the introduction of the silver-wire filigree that any procedure intended for the betterment of such cases was attended with anything like uniform good results. A step was taken in the right direction when the late lamented Schede commenced to suture simple abdominal wounds with silver wire, but this valuable procedure is of course of no avail in those instances where the lips of a defect cannot be approximated, no matter how great the tension applied, as has been the case in several operations which I shall detail later. It was in the effort to remedy this state of affairs that Witzel constructed in the tissues, during the operation, his first rude net-work of cross-wires, and in so doing suggested to the surgical world the idea of embedding a ready-made filigree. He drew the edges of the wound as near together as possible with ordinary heavy silver sutures which penetrated muscles and fasciæ; then, after these had been tied, ran slender wires in every direction across the opening which remained, hoping in this manner to sufficiently reinforce the scar tissue which should form between and around them.

A quicker procedure, and one which is valuable where the wound edges can be almost or entirely approximated, is that of Phelps, who has treated many inguinal herniæ by placing coiled silver wire on the floor of the canal, and then suturing the other layers of the abdominal wall over it. This alone would not, however, be sufficient for the closure of a large gap, because the small wire coils, lying side by side, could not possibly offer that strong support which can be gained only by anchoring in healthy tissues, wires which shall run like the trusses of a suspension bridge, straight across the weaker portion of the field. Goepel, who was the first to make use of the ready-made filigree, evidently appreciated this principle, for he, by implanting one four by six inches in size upon the muscular layers, was enabled to supply an exceedingly large segment of the abdominal wall. Another of the very few surgical writers

who have given us any account of the results attained in this way is Meyer, who reports three cases successfully treated with a netting made up in just the same way that ordinary mosquito bar is constructed. There were certain disturbances in the after-course of one of his cases, but in the end he attained satisfactory results in all three. The disturbances to which I have just referred led to a secondary operation in one instance, and can in my mind be explained by the stiffness of the filigree used, this stiffness being the very objection which I have striven to eliminate in the construction of the little contrivance proposed herein.

All of the above-named authors secured essentially the same results by following the same general line of treatment, but there was considerable difference of detail in the work of each, which becomes a matter of greater import as we go deeper into the subject. Let us then review the technique of the various operators, in order to be able to construct a netting which shall possess none of the features that have proven objectionable in the hands of others, one which shall offer the patient the greatest security together with the minimum possibility of discomfort or danger. One can readily imagine the difficulty of Witzel's procedure of manufacturing a filigree in the tissues while an operation is in progress; but he cannot know just how hard it is until he has tried it. I most heartily subscribe to the idea of putting in a ready-made filigree, for the further very good reason that the surgeon who has measured the wound before operation and manufactured the wire support beforehand can, as a matter of course, make for his patient a much more satisfactory as well as a better fitting one than any which can be devised while the individual is upon the table, amid the hurry and embarrassing surroundings of an extensive surgical procedure. It is equally important that the ready-made filigree can be anchored between the tissue layers at a much greater distance from the lips of the wound than is possible where the whole thing must be made with a needle while the wound is open; it being a matter of physical impossibility to perfectly elevate the tissues and to work between or beneath them at a

great distance from the free wound edge without more handling of the tissues and more laceration than is commensurate with satisfactory healing and repair. It is necessarily a slow procedure and likely, in consequence, to be attended with faulty asepsis, while much as a matter of course depends upon this last-named factor, especially since a foreign substance is being incorporated in the body tissues. Then the small silver coils of Phelps cannot be expected to support the scar barrier across a large new opening, useful as they are in their proper place. Those at the periphery would no doubt hold perfectly, while those at the centre, not being attached to them, would as a matter of course allow of separation from the others. The net used by Meyer has been referred to as possessing more stiffness than desirable, when the tissues in which it is to be embedded are extremely pliable, and should in my opinion be subjected to the presence of only such a filigree as will permit the exercise of this quality to the fullest extent. Dr. Meyer's net-work consisted of wires crossing at right angles and equidistant from one another, which method of weaving cannot fail to lend a more or less board-like consistence to the finished product. My results attained in the use of a less bulky contrivance will show that there is no necessity for such a number of wires running in two directions.

The form of filigree which I herewith introduce depends upon the knowledge that scars in the abdominal wall spread laterally but not longitudinally to any great extent, and my results in the cases to be described bear out the truth of this line of reasoning. After considerable observation, it seems to me illogical to strengthen the scar with a great number of needless wires which run parallel to the axis of the incision and which, beside being of no avail, can by their presence serve only to stiffen the abdominal wall, and thus prevent the perfect mobility which has been mentioned as essential to it, being, so to speak, a prerequisite of the patient's comfort.

My filigree depends, as you will see by the appended illustration (Fig. 1), for its efficacy upon the fact that all but one of its wires run across the long axis of the scar and penetrate

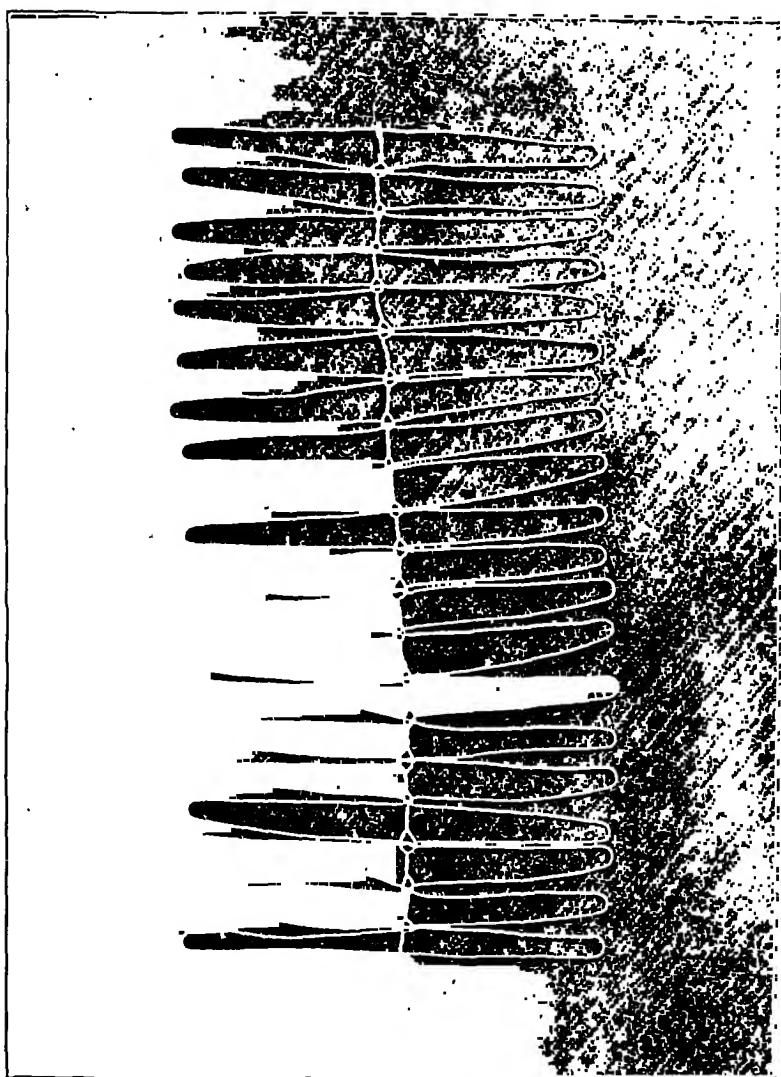


FIG. 1.—Represents the form of filigree which is proposed for general use.

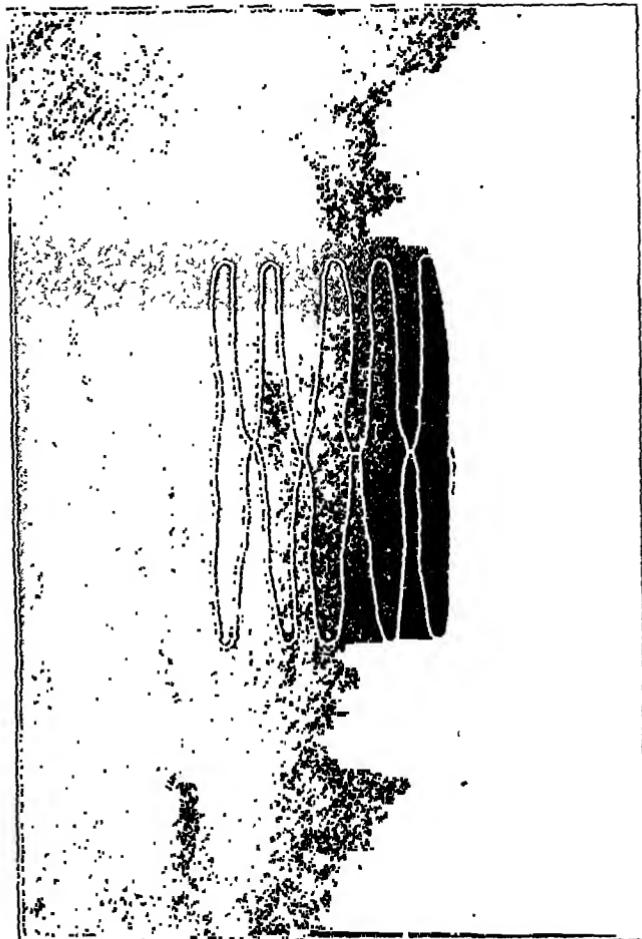


FIG. 2.—Represents a modification of No. 1 (without the median connecting wire). The cut shows only one-third of a net which should be the same size and shape as that in Fig. 1.

for a distance of one or two inches between the tissue layers, where they are firmly anchored, not by sutures, which I consider perfectly useless in this connection, but by newly formed scar tissue, which naturally fills out the opening of each loop while the patient is in bed after the operation. I purposely bend each of these cross-wires into the form of a loop in order that there shall be no sharp irritating ends anywhere; and, further, I lay great stress, in constructing my filigree, upon the fact that each of these loops be entirely separated at the free end from its neighbor; thus it is seen that the minimum of stiffening is imparted to the tissues by the single longitudinal twist which binds the several loops together in the median line of the contrivance. This last-named wire strand appears necessary to prevent the possibility of a hernia between two of the cross-wires, which might easily be forced slightly apart if they were not fastened together at all. One can hardly imagine the difference in pliability between such a filigree and one woven of wires crossing at right angles and equidistant from each other throughout the whole field. The latter, by its rigidity, can have only the effect of robbing the abdominal wall of much of its natural pliability.

In cases that allowed of no accurate determination beforehand as to the size of filigree desired, I have used a form of net which differs slightly in its construction from that described above. The illustration (Fig. 2) of a short one given herewith shows that this can be drawn out or shut up like an old-fashioned hat-rack. It is different from Fig. 1, inasmuch as no median wire-twist binds the cross loops together; however, this has been compensated for in my work by sewing it in place with a continuous suture of fine wire, being careful to loop the suture around each point of crossing in the filigree.

Nothing is easier to make than one of these wire nettings; after trying several methods, I have found it simplest to drive wire nails through a board (their distance apart being regulated by the size of the filigree desired), after which the board is turned over and the points of the nails are used to string the loops upon, much as the lace-weavers use their pins. The one

shown in Fig. 1, with twenty loops on either side, is five by two and one-half inches in size, one which has been found convenient in postoperative herniæ. As to the distance between the cross-wires, I can only say that experience has not yet shown that it is to be improved upon. The shape of the contrivance, too, can be modified as the surgeon may see fit; for the inguinal region a triangle has been suggested, and this would surely suit the requirements of the region if one of its sides were fitted to Poupart's ligament. It has been my practice to make use of a gauge 27 silver wire, with which I have as yet no fault to find; I tried aluminum bronze once, but found it far too stiff for the purpose.

It seems that most of the surgeons who have used a filigree have sewn its edges firmly into the tissues, something which I believe to be entirely superfluous. I have never done anything of the kind; still, none of my seven have shown any disposition to pull out. It is surely sufficient to attach the longitudinal twist to its tissue bed by a few sutures, and thus prevent the filigree from slipping before the operation is finished; but any further attachment is merely a waste of time and a needless tissue laceration, since there can be no displacement after granulations have filled out the loops. Then, too, scar formation is certainly complete before the patient is let out of bed at the end of three weeks, as has been my practice. I have but to mention the well-known difficulty of removing gauze or a fenestrated drainage tube into which granulations have grown, to quiet any fears that may obtain as to a filigree moving while the reparative process is going on.

It is hardly possible, regarding the layers between which the filigree should be inserted, to formulate a rule which will cover every case. This is a matter which has depended, in my practice, largely upon the ease with which certain layers have come apart. It may, however, be stated as a general conclusion that it is logical to place the contrivance as deeply as possible, especially since it is used chiefly where the wound edges cannot be brought together, and dead spaces must be obliterated. Suppose an instance in which only peritoneum (with attached

fat and transversalis fascia possibly) and skin can be entirely brought together, then it must appeal to any one as being better that the filigree rest upon the floor of the defect rather than outside the muscles, for it is then easier by pressure or suture to prevent the formation of dead spaces between filigree and skin than those between filigree and peritoneum. In no case is the appliance to be placed upon the aponeurosis of the external oblique, since an exposure of that tissue, sufficient for the purpose, must result in a necrosis of it, on account of the cutting off of its blood supply which comes through its covering of fat.

It may seem like a radical stand to take, but experience teaches me that it makes absolutely no difference whether the muscles and fasciæ be or be not completely drawn together as long as a suitable wire filigree extending sufficiently far out between healthy layers be properly implanted and heal in. I have had the opportunity of observing that the anatomical and functional results are just as good where the newly formed segment of the wall is composed of peritoneum, wire, and skin, as is the case under any other circumstances which the most imaginative mind can conceive.

After observing how well my filigrees functionated in several patients, I became naturally curious to learn just how much tension the loops could withstand, after being anchored in no other way than by scar tissue formed in them; so I opened up the abdominal wall of a small dog, separating the intact peritoneum from the overlying structures in the median line, where I embedded a small filigree like Fig. 1. This small contrivance had only eight loops on each side, and projected out but three-fourths of an inch under the edge of the wound, not being sutured in position at all (to make the test the more severe). The recti were then sewn together with a continuous silver wire as was their anterior sheaths, the skin being united by interrupted sutures of silk. The animal was then turned loose without a dressing of any kind, and from the second day he ran around as such animals are accustomed to do under ordinary circumstances, furnishing in this way what can well be considered a crucial test for this method of wound closure.

At the expiration of four weeks, the wound having healed completely, I cut down at one side of the original incision, until the loops forming one edge of the filigree came into view; into four of these I fastened a hook, and then it was only after a tension measured by eleven pounds on a spring balance had been applied that I managed to loosen the hold which four loops on the opposite side had secured. It was then by no means possible to lift the filigree from its bed; the best that could be done in this line was to tear it to pieces, so firmly had nature anchored it. While such an experiment does of course not actually indicate the amount of resistance which such an appliance will manifest against the intra-abdominal pressure directed against its median portion and at right angles to the direction of its cross-wires, still, this is enough to demonstrate that forty such loops, forming both sides of the filigree which I have used on the human subject, will certainly manifest sufficient resistance for all practical purposes, when it requires a full eleven pounds to dislodge only four of them.

There is still another question of decided importance which comes up in this connection, upon which I regret to say we have no definite information, *i.e.*, the influence of such a device upon the abdominal wall of a growing child or upon that of a pregnant woman. Does it have the effect of retarding or of misdirecting the expansion of the part affected? Or do other segments compensate, by an unusual increase in their dimensions, for what is lacking in this new condition of affairs? However this may be, I cannot throw light upon this subject, as I had at one time hoped to do; for, as you will later learn, one of my patients, three and one-half years old, in whom I implanted such an appliance, died long before sufficient time had elapsed for her to furnish us with satisfactory data bearing upon this point.

CASE I.—Ruby G., three and one-half years old, colored, fell some six weeks ago, striking the right side against a hall banister. At the site, between last rib and crest of ilium, there is now a rapidly growing soft mass the size of a lemon; no increased tem-

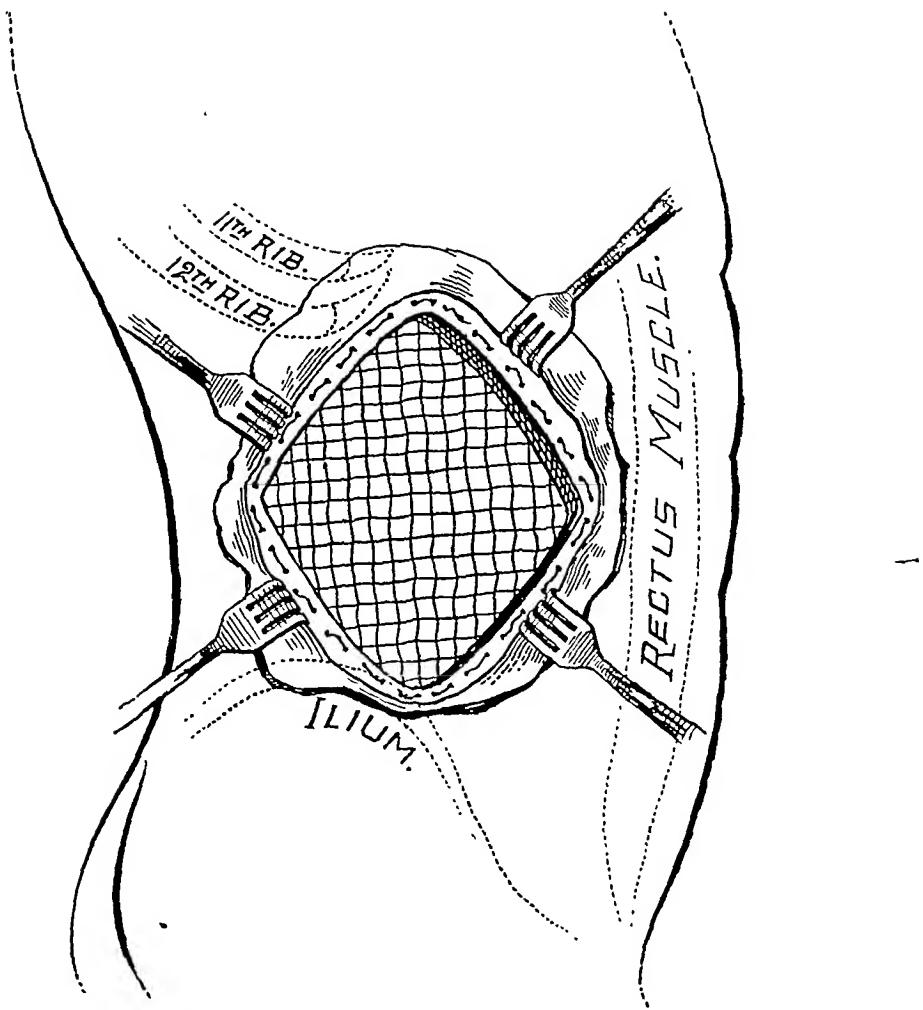


FIG. 3.—The form of filigree which was built up in the tissues during operation in Case 1.



FIG. 4.—Photograph of patient No. 1 two months after operation.

perature, no fluctuation, and no change in the skin, which is free from the mass in the deeper layers of the abdominal wall. On April 5, 1901, I excised at the Provident Hospital what was found to be a small round-cell sarcoma, taking at the same time every tissue which was in any way connected with it. After retraction of extensive skin flaps, I removed a rectangular segment of the abdominal wall down to the subperitoneal fat, which was in no way connected with the tumor; this segment contained the twelfth costal cartilage in its upper angle, a portion of the crest of the ilium in its lower, while the anterior portion of the defect exposed the rectus abdominis; and the posterior, the vertebral column. It was manifestly impossible to close so vast a defect by any form of autoplasty, so I set about to construct in the tissues a filigree. This I did with gauge 25 silver wire, being careful to anchor every strand through and through all the tissues except the skin and peritoneum; just how this was done is perhaps better shown by Fig. 3 than any words of mine can describe. There was absolutely no bulging when the patient struggled in the effort at vomiting, so the skin was sewn over the net-work and the child put to bed. The wound healed by first intention, and in three weeks the little one was allowed to get up and run around. There was never at any time evidence that the patient realized the presence of the filigree, nor did the wall ever bulge at the site; in fact, there was never a manifestation of those undesirable consequences which must have followed such an operation had no such means of closing the abdomen been adopted. Fig. 4, made from a photograph taken two months after the operation, shows conclusively that the wire net did its work. This most interesting subject, from whom I had hoped much in the way of showing what effect a filigree has on the development of the abdominal wall, died, three and one-half months after the operation, of a recurrence *in situ*. The wires were found to be evenly scattered through the new masses of sarcoma tissue.

CASE II.—Mr. S., middle-aged white man, on whom omentopexy (Talma's operation) had been performed six months before I treated him. His hepatic cirrhosis manifestations had improved in many respects; still, there was sufficient reaccumulation of the ascitic fluid to cause a small hernia; though I can say from personal observation that the former operation had been well done, and that the wound had healed by first intention. So much

discomfort was caused by this hernia that he applied to me for a second operation, and June 8, 1901, I implanted a filigree at the Rebekah Hospital. The sac was dissected out, the recti and their sheaths being freely exposed, but the peritoneum not opened. I placed upon the floor of the wound thus formed a filigree, two by four inches in size, of aluminum bronze wire gauge 30. This contrivance was not quite like those which I now use, being made up of cross-wires woven over a single wire frame; however, it was a step in what I have learned to consider the right direction, since it did not have a large number of wires running parallel to the incision, and thus adding stiffness to the net. As is stated in what has gone before, I have discarded any sort of permanent frame, preferring to have all the cross wires end in separate loops. I did not let out the excess of ascitic fluid; hence the muscles and their sheaths failed to meet over the filigree by almost an inch; their edges were separately made to approach within an inch of each other by the use of a running suture of silver wire; and when the skin was united over this, it is seen that a portion of the anterior abdominal wall consisted of nothing but peritoneum, wire filigree, and skin; that, too, in an individual whose abdomen was gradually filling with ascitic fluid. Could a more severe test of the method be imagined? What I have just said applies to the lower four-fifths of the wound, which is still intact after two years have elapsed. I cannot say as much for the upper fifth, the portion which my filigree did not quite cover; at the operation I covered the small defect with coils of wire fashioned after those of Phelps; still, this part of the wound broke down as soon as the patient got out of bed, and there is now at the site a bulging area about the size of half a walnut. It causes no trouble, however, so he will not allow a reoperation. Nothing of what is written here is meant in criticism of Phelps's valuable method; he probably never meant for it to be used where nothing but skin lies in front of the wire and nothing but peritoneum behind it. While I am far from considering lightly human health or comfort, still, I cannot repress a certain feeling of satisfaction over the reoccurrence of a hernia in the portion of this wound not covered by the filigree; nothing else could so perfectly demonstrate the value of the filigree as this living exposition of the difference between that portion of a wound thus protected and that to which no such protection is afforded.

CASE III.—Miss Y., aged eighteen years, was operated upon at St. Anthony's Hospital, July 1, 1902. She was a beautiful and accomplished young woman, whose plight was especially pitiable for these reasons. She had been operated upon for a suppurative appendicitis five years before, and the wound drained for weeks with gauze and rubber tubes. The unfortunate girl had had a hernia ever since getting out of bed; at the time I saw her there was a skin scar one and one-half inches broad by six inches long, which furnished but a thin covering for the hand as it was inserted through a large opening directly into the abdominal cavity. She had worn an abdominal "binder" from the time of the first operation, hence the hernia had been prevented from assuming large proportions. Even with this support she was unable to stand for more than a few minutes at a time; nor could she run, dance, skate, or engage in anything which required an actual exertion. She could not stand straight at all, while her subjective symptoms of weakness and discomfort were most marked. But it was only after removal of her supporter that the actual meaning of such a condition for an otherwise healthy young girl became apparent. She could not stand long enough for me to make a thorough examination of the old wound, and assured me that she had actually not been upon her feet, without the bandage, since the operation of five years before.

I excised the large skin scar, freshened the edges of the aponeurosis, dissected away scar tissue until I had a new muscle wound formed on one side by the rectus, on the other by the internal oblique, and replaced into the abdomen the sac, to the interior of which omentum was widely attached. The muscles could not be brought together without too much tension, so I placed a small filigree made like Fig. 2 on the floor of the defect, and then drew the muscles as nearly as possible together with four Halsted mattress sutures of gauge 23 silver wire. The edges met in three of the sutures, but the fourth left a gap of about an inch immediately over the filigree just mentioned. Upon the muscles I placed a filigree like Fig. 1, one and one-half by five inches in size, completely uniting the aponeurosis over this by a continuous suture of silver wire. After uniting the skin with a subcuticular suture, we put the patient to bed, where she lay for three weeks without an incident to mark the perfect recovery. She got up from bed a changed girl; there was no

feeling of weakness in the abdominal wall, nor any sense of discomfort whatever; she felt no desire for the old-time "binder," nor has she had it on since. The right side of the abdominal wall was, as far as her feelings went, exactly like the left, *i.e.*, perfect. This patient's brother informed me seven months after the operation that his sister then walked a mile to school every day, danced like other girls, and had skated the entire afternoon and evening previous to our conversation. Could one hear a more satisfactory commentary of the silver filigree? Nine months after the operation, I received a letter from the young lady, stating that she then weighed some twenty pounds more than she did when she left the hospital, and was otherwise in perfect physical condition.

CASE IV.—Mr. H., fifty-five years old, short, stout, and plethoric, had been operated upon for appendicitis one year before he came under my treatment; it had been a non-suppurative case, and the abdomen had in consequence not been drained, but sewn tight. Nevertheless a hernia had developed shortly after he left the hospital, and when I examined him I found three separate small sacs protruding with their contents of hollow viscera between the sites of the original through-and-through sutures. This patient, like the foregoing, was in constant misery; he suffered actual torment, though he wore a binder; was the subject of colicky pains or constipation all the time, and was, generally speaking, about as miserable as a man can be. I excised everything from the skin to the sac, at the same time freshening the aponeurosis and muscle edges as in the case just described. The openings into the sac were so small that I was afraid to reduce them lest an intra-abdominal constriction might occur. Three Halsted mattress sutures of wire closed the large opening in peritoneum and muscles, then upon the floor thus formed I placed a filigree like Fig. 1, six inches by two and one-half inches in size. Over this the aponeurosis was sewn with one continuous wire and the skin with another. This operation was done at St. Anthony's Hospital, July 28, 1902, and the patient left his bed at the expiration of three weeks a well man in every particular. I saw him eight months after the operation, when I was assured by him that he had never during that time been reminded of the presence of the filigree, nor had he been other than a perfectly well man as far as his abdomen was concerned. This for an elderly gentleman with a pendulous abdomen, who had suffered acutely.

CASE V.—Mr. P., sixty-seven years of age, was operated upon at the Lutheran Hospital, August 12, 1902. The old gentleman suffered from cirrhosis of the liver, with much ascites, and an umbilical hernia the size of a child's head. The heart and kidneys, however, manifested no evidence of change, so I determined to make his condition more bearable if possible. At the operation the sac was found to be filled with small intestines, which were reduced without difficulty through a ring two inches in diameter, there being but one small adhesion. All the coverings on the hernia were extirpated, the surfaces of the liver, spleen, and abdominal wall vigorously rubbed, and the omentum fixed according to Talma's method. Then the layers of the wall around the ring were carefully dissected apart, so that the peritoneum and posterior coverings of the rectus could be united in a single running wire suture. Upon the layer thus formed there was implanted a filigree corresponding to Fig. 1, the dimensions of which were five inches by two and one-half inches. The edges of the very atrophic rectus, together with the anterior sheath, were united over this contrivance with a continuous heavy wire suture. Upon this fibrous layer was fastened a filigree two and one-half inches square and the skin sewn over all. There were no untoward symptoms for four days, at the expiration of which time I departed for Colorado on my summer vacation. What was my surprise, upon returning to the city several weeks later, to learn that, eleven days after the operation, the patient, who was apparently doing well up to that time, had been seized with sudden nausea and expired in ten minutes. No autopsy was made, so I am at a loss for an explanation of the unfortunate occurrence.

CASE VI.—Mrs. S., aged forty years, was operated upon at St. Anthony's Hospital on the 20th of January, 1903, there being removed from the groin what proved to be a carcinoma. I excised skin, subcutaneous tissue, and aponeurosis as well as fascia lata from an area about the size of a man's palm, distributed two-thirds of it above Poupart's ligament, and extending from the superior anterior spine of the ilium most of the way to the spine of the pubis. The defect in the fibrous structures could not be obliterated by simple suture, and, fearing to trust to the muscles alone for maintaining the integrity of the abdominal wall, I implanted a filigree like Fig. 2, consisting of ten loops on either side. This was laid on the muscle floor of the wound, while over

its borders was drawn the edge of the aponeurosis and fascia lata, the crossing of the wires being attached to the stump of Poupart's ligament. A defect about one inch broad by three inches long remained in the fibrous covering of the filigree after the edges of these structures had been approximated as nearly as possible by a continuous wire mattress suture. The skin wound was completely closed by the Michel wound "clips." The recovery was uninterrupted; the patient was up in two weeks, walked without trouble, and there was no bulging. The abdominal wall remained intact up to the time of the patient's death from general carcinosis five months after operation.

CASE VII.—Miss H., aged twenty-two years, colored, had been kicked in the right groin two months before I saw her, and had been in bed ever since. When she endeavored to stand up, there was a decided feeling of weakness in the right lower segment of the abdominal wall, accompanied by a sickening discomfort, which caused her to lie down for relief. She had noticed a bulging at the site of the injury, which corresponded fairly well to the inguinal canal; and, indeed, when she stood for me to examine her it was plain that she had not been mistaken in this particular, the lesion being subject to a pronounced impulse on coughing. The corresponding segment of the wall on the left side showed no evidence of change. It was clear that, though no pronounced herniation had occurred since she had remained in bed, something in the way of a repair must be instituted if the otherwise robust, healthy girl was ever to be of any use to herself or to any one else; so I operated at the Provident Hospital, February 28, 1903. The incision was made high, as recommended by Halsted in his operation for inguinal hernia. As soon as the aponeurosis was split, it was seen that the inguinal canal had not enough intact muscle substance in its posterior wall to prevent the hand pushing the peritoneum before it through a large opening into the abdominal cavity. I had little confidence in the thinned-out muscle, so made no attempt to use it in closing the opening, preferring to merely place a filigree of the style in Fig. 2 on the floor of the defect, and to sew the aponeurosis over it with a continuous silver wire. One side of the contrivance was covered by the shelving edge of Poupart's ligament, and the other extended well up between the internal oblique and the aponeurosis. It was two and one-half inches broad and about

three and one-half inches long when sewn in place; the adjustable feature of it seeming to me an advantage when used in this locality, because this renders it easier of insertion. The skin was united with the Michel wound "clips," and the girl made a perfect recovery, her wound, like all of the other six, having healed by first intention throughout. In two weeks she left her bed without a feeling of weakness or discomfort, and was able to walk for the first time since the injury, some ten weeks previous to this time. I learned from her family physician, some four months after the operation, that her abdominal wall was still in perfect condition, though there is a slight feeling of stiffness in the scar, as she expresses it, this being particularly noticeable when the thigh is strongly flexed upon the pelvis.

My results have been the legitimate outcome of the operations alone; there have been no favoring circumstances to which may be attributed a share in preventing the expulsion of the filigree by the intra-abdominal tension. I mean by this that I have not allowed one of my patients to wear any sort of binder or support or abdominal bandage after the operation, preferring to put the filigree solely on its merits.

It will be seen from the foregoing that I have done this comparatively new operation seven times, and have seen uniformly perfect results in all but one case. Here the slight partial bulging which resulted under the influence of an ascitic collection was in no sense the fault of the method, but due, on the other hand, to a technical flaw. This was the first instance in which I had inserted a ready-made filigree, and in my inexperience I made it too short. Then in inserting it I fully covered the lower angle of the wound, since I realized that the greatest intra-abdominal pressure must come at that point. I had measured this man's scar and hernial opening before manufacturing the filigree, but learned, during this my first operation of the sort, that a proper dissection in such a case requires that the new wound must be made *much* larger than the old scar. Based on this, I should advise others to make the filigree at least one and one-half times longer than the scar which it is to replace.

I have been able to observe my seven patients after operation, respectively, two years, one year, eleven months, five months, four months, three and one-half months, and eleven days, and must say that I have not had to remove a filigree, nor have I seen any disturbance which might be taken to indicate that such a contrivance could not rest indefinitely in its new bed.

The logic of the operation is simple; in it we place no dependence on preformed tissues; in fact, we entirely leave them out of consideration and pin our faith on a new scar, which is prevented from stretching under tension by unyielding silver wires distributed through it in the proper direction.

My opinion of this recent idea in surgery, after giving it the test which I have, cannot be expressed too enthusiastically. The filigree renders easy something which would in many cases be otherwise impossible. By its use hopeless invalids may be restored to health and activity. Of all the various forms of netting which have been used, the simple ones of cross-wires proposed herein appeal to me as being the only ones which are free from the evident disadvantages inherent to any sort of plate, such as a stiff filigree really is,—one made up of wires which are equidistant and running in both directions.

THREE SUCCESSFUL LAPAROTOMIES FOR INTESTINAL PERFORATION IN TYPHOID FEVER.¹

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I WISH to report briefly three cases of perforation of the intestine following typhoid fever which were operated upon and recovered. These three cases occurred out of a series of thirteen in my service at the Episcopal and Pennsylvania Hospitals.

CASE I.—December 4, 1900, Episcopal Hospital. Male, aged twenty-nine years. Perforation in the third week of the disease. Since being in bed has had some sharp pain in lower abdomen. At 11 A.M. had a sharp, severe pain in the hypogastrium immediately after using the bedpan. Two hours later had a severe chill, after which the pulse became rapid and weak. The abdomen was hard, rigid, tender, and painful. I saw the patient in consultation about that time and advised immediate operation, but owing to delay in obtaining permission from his family, he was not operated upon until five and one-half hours from the time of perforation.

Operation.—Ether. Incision along the right rectus muscle. On opening the abdomen a large amount of turbid fluid escaped; intestines and omentum red and congested; appendix adherent but not perforated. After the withdrawal of a number of coils of ileum, a small perforation was found about ten inches from the cæcum, apparently the centre of a Peyer's patch that was ulcerated, and which was easily closed with silk. A small amount of faecal matter had escaped, which was easily washed off with hot salt solution. After the abdomen and pelvis were thoroughly douched with normal salt solution the intestines were replaced.

¹ Read before the Philadelphia Academy of Surgery, April 6, 1903.

A glass drainage tube was carried well down into the pelvis, and the wound partially closed. The appendix was removed. Temperature, $103\frac{3}{5}$ ° F.

The convalescence was slow. In about three weeks the wound was closed. A week later the patient developed an empyema, which necessitated the introduction of a large drainage tube into the pleural cavity. Cultures from pus showed colon bacilli, streptococci, and bacillus *fœtidus*. The patient rapidly recovered, and was discharged cured eighty-three days after operation for typhoid perforation.

CASE II.—Male, thirty-nine years of age. Pennsylvania Hospital. Admitted May 4, 1902. Had been sick for about ten days. On admission presented symptoms of peritonitis. Abdomen was tender and board-like. As soon as possible the patient was prepared for operation. Under ether, incision was made on edge of right rectus muscle; on opening abdomen about two pints of lemon-colored fluid escaped with flakes of lymph. Appendix much swollen and congested and was removed. Some distance from the cæcum a perforation was found in the ileum, which was closed with two rows of Lembert silk sutures. Much faecal matter had escaped. The abdomen was flushed out with hot salt solution, followed with equal parts of normal salt solution and hydrogen peroxide, and finally with normal salt solution, being then packed with five large pieces of gauze and the wound left open. On the third day after operation the packing was removed. The condition was good; abdomen flat. The gauze was replaced. Two weeks later temperature was normal, wound clean, but not healed. When apparently convalescent, the patient had a typical typhoid relapse, and was removed to the medical ward, where he had a second relapse two months after admission. He was discharged cured three months after operation, with slight ventral hernia.

CASE III.—Male, aged thirteen years. Pennsylvania Hospital. Operation, May 11, 1902. Patient was admitted to the medical ward with typhoid fever on April 4; present illness began on March 28. Ten days before admission had had headache, backache, cough, epistaxis, and diarrhoea. On admission, spleen was enlarged, abdomen soft and flat, temperature high. On the forty-sixth day of the disease the abdomen became distended and tender, with great muscular rigidity, although there was no marked evidence of any sudden perforation. Operation was ad-

vised, although the patient's condition hardly warranted surgical interference. Ether. Rigid cyanotic abdomen, with intense tenderness, rapid dicrotic pulse, and cold extremities. Incision on right side permitting the escape of about half a pint of straw-colored fluid and flakes of lymph. Appendix found in an ounce of pus, gangrenous and perforated, and was ligated and removed. On examination of the ileum, two perforations were found with some escape of faecal matter, and closed with silk sutures. Abdomen and bowel irrigated with hot salt solution, then with equal parts of salt solution and hydrogen peroxide, and finally with normal salt solution. Abdomen packed with large pieces of gauze; wound left open.

The convalescence was protracted and interrupted by two distinct relapses. The patient was finally discharged cured over three months from time of operation. Abdominal wound quite firm.

In reviewing these three successful cases, it will be noticed that they represent one from each of the three classes that are ordinarily brought to the surgeon's notice for operation. In the first one the perforation occurred during the middle of the disease with the patient in good condition, and was immediately recognized and operation advised. The only delay which arose was waiting for the consent of the patient's family, during which time the patient lost considerable ground. The second was of the ambulatory character, coming on suddenly in a patient who was not much exhausted from the effects of the disease, and presenting many of the characteristic symptoms of an acute appendicitis with perforation. This class is decidedly the most favorable for operation, and from it the greatest number of recoveries will be gathered. The third class is the most unfavorable, as the vital energies are almost entirely exhausted as the result of a prolonged and exhausting disease; and it is in these cases that the greatest difficulty is experienced in arriving at an accurate diagnosis whether perforation really does exist or not. Nevertheless, this third class illustrates how ill a case can be when operated upon and yet recover.

The key-note of success in dealing successfully with typhoid perforations is the early recognition of the lesion. At the best this is a most difficult procedure, and the diagnosis can best be made by the medical attendant who has carefully followed the case from the beginning, noticing all the trifling changes that occur in the abdomen. When any undue symptom arises, the surgeon should immediately be consulted, and with his aid and the carefully acquired knowledge of the medical attendant a correct diagnosis can generally be made. The classic symptoms of perforation when well marked can hardly be mistaken, such as pain, tenderness, rigidity, shock, chill, facial expression, and all the symptoms of peritonitis. To make an accurate diagnosis of perforation in the early stage, the medical attendant must be thoroughly conversant with the condition of the abdomen, and must be alert for the first symptom of muscular rigidity, which is one of the earliest and most important signs of intraperitoneal irritation.

Rigidity and spasm are terms so loosely used and so difficult of apprehension that it is not easy to reconcile oneself to these recorded statements. I believe that rigidity as understood by the surgeon differs from that interpreted by the physician, and, as just stated, is most difficult to properly estimate its significance in many cases; but if this sign is rightly interpreted, it is the key-note to the early detection of a perforation in a large proportion of cases. The ideal method would be for the surgeon to see regularly, in conjunction with the physician, all cases of typhoid fever day by day. The leucocyte count has proven of very little value at the time when most needed.

Cases with haemorrhage are most perplexing, as these two conditions—haemorrhage and perforation—may exist together, although they did not occur in my series. The absence of liver-dulness and the presence of flank-dulness are late signs, and are of little corresponding value. The facies is of value if carefully noted by the person in attendance, but is difficult to read by a stranger until peritoneal involvement is very marked.

Shock is regarded by some as an important symptom, and is undoubtedly present if sufficient time is allowed for its devel-

opment. No time should be wasted hoping that reaction will take place, for as every hour passes the greater will be the leakage from the intestine, causing greater soiling of the peritoneum. Immediate operation will enable us to prevent further soiling of the peritoneum, to repair the injury to the bowel, and reduce the danger of septic inflammation by suitable toilet followed by drainage, and also combat the existing shock and aid reaction by douching the abdominal cavity with hot salt solution.

Immediate operation should be urged even in the presence of profound shock, as every hour of delay proportionately decreases the chances of recovery.

The incision is preferably made on the right side, and is almost sure to lead down to the seat of perforation, which is always within a short distance of the cæcum. In hunting for the perforation, it is a good rule to start with the cæcum and appendix; then the last three or four feet of the ileum are examined, and as much of the ascending colon as can be exposed. If no signs of peritoneal infection are recognized during this examination, an error in diagnosis has been made, and further operative interference should be discontinued. If, however, signs of peritonitis are apparent, and the cause is not detected, a median incision should be made so that the entire length of the colon and the remaining small bowel can be carefully examined. A perforation may be easily hidden from sight by a piece of lymph, therefore all portions of the bowel that are indurated or covered by lymph should be carefully examined. It is safe to say that the lateral incision will be found the most satisfactory in 95 per cent. of cases operated upon. Out of 332 cases which I have carefully analyzed, in ninety-six the median incision was made with a mortality of 78.12 per cent. In the right lateral incision there were 123, with a mortality of 68.37 per cent. In the other cases operated upon, the site of incision was not mentioned. The more improved technique has undoubtedly reduced the mortality in these operations, which will be noticed in the appended table.

RICHARD H. HARTE.

TYPHOID PERFORATION.

Recovered, 87; died, 245; total, 332; mortality, 73.79 per cent.

Operations.	Recovered.	Died.	Total.	Mortality.
1884-1888.....				
1889-1893.....	1	9	10	90 per cent.
1894-1898.....	2	14	16	87.5 per cent.
1899-1903.....	28	82	110	74.5 per cent.
	45	101	146	69.1 per cent.

In fifty cases, year of operation not stated.
Mortality for male sex, 78.5 per cent.
Mortality for female sex, 61.4 per cent.

When the perforation has been found and its closure will not produce too great stenosis of the bowel, it should be rapidly closed with silk sutures in whichever direction, either transversely or longitudinally, to the lumen of the bowel which produces the least narrowing of the gut. No time should be wasted on attempting to trim or freshen the edge of the ulcer, as the area of the bowel near a perforation is always so friable that stitches are liable to tear out. The best stitch for this purpose is the so-called mattress suture, as a running Lembert is liable to cut or tear through the friable tissues. When the opening is closed, the bowel should be carefully inspected for other perforations, as not infrequently these openings are multiple. Often dark necrotic spots will be found where the ulcer has destroyed the coats of the bowel down to the peritoneum, giving the appearance that in a short time another opening would be formed. All such suspicious places should be treated as though a perforation had taken place, and the weakened area fortified by being folded in with stitches. Occasionally, cases will be met with where the opening in the bowel is too large or the area inflamed too great, so that closure is not practicable. When this condition exists, there are four procedures offered. First, a plug of omentum may be so fashioned and stitched against the opening in the bowel as to form a simple patch, after the manner in which Nature sometimes deals with these conditions. Second, resection of the

bowel and an end-to-end anastomosis either with stitches or with a Murphy button, the latter being much more rapid. Third, the formation of an artificial anus by stitching the bowel to the abdominal wall, and, fourth, cutting off the damaged area of the bowel from the general peritoneal cavity by carefully placing pieces of gauze between the folds of the bowel.

The cleansing of the peritoneum and drainage are the most important procedures. It has been decided by some that when only the right lower quadrant of the abdomen is infected, the intestine should be brought outside of the abdomen and carefully cleansed with salt solution and gauze sponges, while the cavity within is sponged dry.

My best results have been where the peritoneum has been dealt with by vigorously flushing with salt solution, then with equal parts of salt solution and hydrogen peroxide, and finally douching with normal salt solution. This is best done by carrying a large tube down into the pelvis, and with vigorous flushing all foreign matter can be much more easily removed than by attempts at dry sponging. After the intestines are carefully replaced in the abdomen, a number of large gauze wicks are carried down to the bottom of the pelvis and to the different parts of the abdomen between the coils of intestine, so as to secure good free drainage. Little or no attempt should be made to close the abdominal wound, except it has been unusually large, when a couple of sutures at the upper angle can be introduced. The wound should have a liberal dressing of gauze applied over it, as it will in a short time become thoroughly saturated with fluid from the abdominal cavity through the medium of the gauze drains. These should not be disturbed for three or four days, after which time they can be removed without much difficulty by thoroughly saturating them with salt solution or hydrogen peroxide. They then should be replaced with a fresh gauze pack, which may be of less quantity, according to circumstances.

In reviewing my work in this gloomy field of surgery, I feel convinced that there are two important factors to be carefully considered. First, the early recognition of the lesion and

dealing with it as rapidly as possible, in order that as little time as possible will elapse from the time of perforation until operation has been performed; and, second, that the operation should be so planned, since time is so important an element, that not a moment should be wasted during it, the technique being of the simplest character, as every moment of delay will cause a much higher percentage of mortality.

THE SURGICAL FEATURES OF PERFORATION OF THE INTESTINE IN TYPHOID FEVER IN CHILDREN.¹

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IN 1898, Keen, in a monograph on the surgical complications of typhoid fever, collected eighty-three cases of typhoid perforation of the bowel which had been operated upon. In 1900 he published a paper on the same subject,¹ and reported 158 cases gathered from medical literature with 23 per cent. of recoveries. Up to March, 1903, I have found 131 additional cases, making 289 in all, with seventy-five, or 25.9 per cent., recoveries. Twenty-five of the patients were less than fifteen years of age.

During the past year I have operated upon a case of typhoid perforation of the intestine in a child of six and one-half years of age, the history of which follows:

Typhoid Fever; Intestinal Hæmorrhage; Perforation of the Intestine on the Thirty-third Day; Laparotomy and Suture of the Perforation; Recovery.—Becky H., six and one-half years of age, was admitted to the children's medical service of Dr. Koplik during the service of Dr. Heiman on July 26, 1902. The child was in the fourteenth day of a fairly severe attack of typhoid fever, with temperatures rising from 104° to 105° F. every evening, a pulse of 130 to 150, and respirations of 36 to 42. There was a well-marked Widal reaction in a dilution of 1 to 50.

On August 4, the twenty-third day of the disease, the patient had a small intestinal hæmorrhage, and at the same time developed a purulent discharge from both ears. The leucocytes varied between 7000 and 11,000.

¹ Read at the meeting of the Pædiatric Section of the New York Academy of Medicine, April 9, 1903.

On August 13, the thirty-second day of the disease, the temperature dropped in nine hours from 102.4° F. to 97.6° F., and the patient had several fluid blood-stained stools. At nine o'clock in the evening the patient had a severe chill followed by a rise of temperature to 104.6° F. and of the pulse to 160.

At 1 A.M. of August 14, the thirty-third day of the disease, the child complained of abdominal pain, and the abdomen was found to be slightly tender, but not rigid or distended. Leucocytes, 11,000.

At 9 A.M. the temperature had again dropped to 101.2° F. and the pulse to 148. The abdomen was found to be slightly distended; there were slight general abdominal tenderness and rigidity; the area of liver-dulness was somewhat diminished. At 2 P.M. the temperature was 99.6° F.; at 3 P.M. it was 102.4° F.; the pulse 140, and of very poor quality.

Surgical consultation at 4 P.M. The child was lying in bed with a pinched and anxious face, its thighs flexed upon the abdomen, and crying with pain. Abdomen considerably distended and fairly rigid; general abdominal tenderness most marked on the right side; liver-dulness partly obliterated; some dulness on percussion in the flanks; the child has just vomited. Temperature, 104.4° F.; pulse, 160; respiration, 40; leucocytes, 18,000. The diagnosis of perforation was concurred in and the patient transferred to the surgical service of Dr. Lilenthal for immediate operation..

5.30 P.M., chloroform anaesthesia; incision three inches long along the outer border of the right rectus muscle; peritoneal cavity found to contain gas and a large quantity of cloudy, inodorous fluid. Several distended and injected loops of small intestine presented in the wound and were packed aside with gauze. A perforation in the wall of the ileum was found about twenty centimetres from the ileocaecal junction; the opening was about the size of a pin's head, and thin yellow faecal matter was oozing from it. The perforation was closed by a double layer of Lembert sutures passed in the long axis of the bowel. As no other perforations were found, the peritoneal cavity was sponged out as thoroughly as possible and the abdominal wound closed with through-and-through sutures of silkworm gut, a small drain having been inserted in the lower angle. Duration of the operation, eleven minutes.

At the completion of the operation the pulse was 200 and

hardly perceptible; after energetic stimulation it dropped to 180, and improved in quality.

August 15. Temperature, 100.4° to 104.4° F.; respiration, 40 to 28; pulse, 160 to 140; general condition poor; delirium; some vomiting; small quantity of gas expelled after enema.

16th. Temperature, 99.6° to 102.6° F.; respiration, 30 to 28; pulse, 148 to 138; no vomiting; pulse improved in quality.

17th. Large furuncle on left hand incised; no vomiting; abdomen soft and hardly tender; fluid nourishment taken well.

19th. Profuse discharge of pus containing staphylococcus aureus from both ears; scalp shaved and numerous abscesses on scalp opened; abdominal wound has healed by primary union except for drainage opening; drain and some of the sutures removed; leucocytes, 9000.

August 27. For the past week the temperature has fluctuated between 98.6° and 102.6° F.; the pulse between 110 and 130; the respirations between 26 and 30. All abdominal symptoms have disappeared; the abdomen is soft and not tender; the bowels have moved regularly; large quantities of fluid nourishment have been taken.

On the 21st several new abscesses on the scalp and on the 27th a large abscess in the left axilla were opened. The pus from the various abscesses contained the staphylococcus aureus in pure culture.

August 29. General condition good; temperature, pulse, and respiration practically normal; leucocytes, 9000; profuse vaginal discharge containing the bacillus typhosus in pure culture (Dr. Bernstein); discharge from ears has ceased after appropriate treatment; patient has gained considerable flesh and strength.

September 2. Temperature, 98.4° to 100.2° F.; respiration, 22 to 28; pulse, 106 to 120; vaginal discharge has ceased entirely after boric acid douches; abdominal wound firmly healed. The patient was retransferred to the children's service, from which she was discharged cured about two weeks later.

The entire credit for the early recognition of the perforation is due to Dr. Heiman, and to the house physician, Dr. M. Gershel, who studied every symptom with the most scrupulous care. The case presents a few special features of interest.

The child is the youngest on record that has been operated on for typhoid perforation. We have been unable to find the record of any case of vaginal discharge which contained the typhoid bacillus in pure culture, and I consider the case in this respect a unique one. The infection was probably derived from the rectum, perhaps from the thermometer.

The following notes have been kindly furnished me by Dr. E. Bernstein, assistant in the pathological laboratory of Mt. Sinai Hospital, who isolated the typhoid bacillus from the vaginal discharge in the patient. "While the number of cases of infection due to the typhoid bacillus in the male genital organs is comparatively large, the number of such affections in the female is surprisingly small. Particularly is this true of the external genitals.

"Typhoid infections of the uterus have been reported by Blumer,⁵² Dobbin,⁵³ and two cases by Lartigau.⁵⁴ Richardson⁵⁵ gives an account of two cases of abortion in typhoid patients, in which he isolated the typhoid bacillus from the placenta, and from the liver, kidneys, and heart of the foetuses. Williams⁵⁶ succeeded in establishing the presence of the Eberth bacillus in the lochia of a typhoid patient suffering from puerperal sepsis.

"Of ovarian infections the number is still smaller, all being ovarian cysts infected by the typhoid bacillus. Thus, Werth,⁵⁷ Sudeck,⁵⁸ Pitha,⁵⁹ and Wallgren,⁶⁰ each report such a case. Unfortunately, Mabit's⁶¹ case of typhoidal pyosalpinx was not controlled by bacteriologic examinations, and therefore cannot be considered.

"Lartigau⁶² gives a very interesting description of a young girl suffering from typhoid fever, who developed multiple ulcers on the vulva and vagina due to this bacillus, while Takaki and Werner⁶³ report a case of post-typoidal abscess of the Bartholinian gland, from the pus of which pure typhoid bacilli were obtained.

"Our case is unique in being a pure typhoidal vaginitis, without ulceration or abscess formation. The typhoid bacillus was obtained in pure culture from the vaginal discharge, and corresponded in all respects—both in culture and agglutination characteristics—to the Eberth bacillus."

✓ According to the reports to be found in medical literature, there seems to be a wide diversity of opinion regarding the frequency of typhoid perforation of the intestine in children. Morse² did not see a single case among 284 children with typhoid fever (7.7 per cent. of the entire number of cases of typhoid fever) at the Boston City Hospital, while Fitz³ saw seven among 192 children with this disease (3.6 per cent.). Among 1028 cases of typhoid fever in children collected by Holt⁴ perforation of the intestine occurred twelve times (1.1 per cent.). Of 232 cases of typhoid perforation collected by Barthey and Rilliet⁷ only three occurred in children. Among 289 cases of laparotomy for typhoid perforation gathered by the writer, twenty-five, or 8.6 per cent., were in children under fifteen years of age. If we combine the numbers given by Morse, Fitz, and Holt, we obtain 1504 cases with twelve, or 1.2 per cent. of perforations, and if we compare these figures with those for adults (perforation occurs in 1-2½ per cent. of all cases of typhoid fever according to most authors), we see that the frequency of this complication in the young is not far behind that in adults. With due consideration of the variations in the severity of the disease in different countries and in different epidemics, we must conclude that perforation is not so very rare in childhood, certainly not as infrequent as has been claimed by some authors (Henoch,⁵ Baginsky,⁶ Morse,⁸ etc.), and that therefore severe forms of the disease are more frequent than is generally believed.

Writers on the diseases of children agree that most cases of typhoid fever in the young run a very mild course. The disease is usually of shorter duration, the intestinal lesions are often not as well marked, and ulceration is frequently absent.

In children, the pulse-rate is usually high during the entire course of the disease. According to Osler,¹¹ the abdomen is more apt to be distended in the young, though generally only in a moderate degree. Osler states that relapses are more likely in children, and that they more frequently complain of

abdominal pain. It is well known, also, that nervous manifestations are very frequent.

The writers from Johns Hopkins Hospital (Osler,¹² Finney,¹³ Cushing,¹⁴ McRae and Mitchell¹⁵) and others (Shattuck, Warren, and Cobb,¹⁶ etc.), who have made careful studies of the early symptoms of perforation, believe that the attempt should always be made to distinguish between the symptoms of perforation and those of the resulting peritonitis. In many, if not most, cases this distinction cannot be made. The only symptoms of *perforation per se* that we could conceive of, are sudden pain and perhaps sudden abdominal distention and collapse. In the majority of cases, the diagnosis of perforation is mainly made from the symptoms and signs of a sudden affection of the peritoneal cavity itself, that is of a beginning peritonitis.

It is seldom possible to make a diagnosis of impending perforation with sufficient certainty to justify operative interference in this stage (the so-called preperforative stage of Cushing⁹). When such symptoms are present, it must almost always be impossible to differentiate a preperforative stage from an early stage of perforation.

In what follows I shall make no distinction between the symptoms that might be directly due to the perforative lesion of the bowel and those of the early changes in the peritoneal cavity. Nor will the attempt be made to give a full description of the symptoms of perforation in children, which are in most respects similar to those described in adults. Mention will be made of only a few features in which the symptoms in the young differ somewhat from those in more advanced age.

Age.—Of the twenty-five patients operated upon, fourteen were between nine and twelve years of age. The ages of the patients follow: six and a half years, one; seven years, two; eight years, three; nine years, four; ten years, four; eleven years, three; twelve years, three; thirteen years, three; fourteen years, two; fifteen years, one.

Sex.—Eighteen of the patients were of the male sex, six were females, and in one patient the sex was not given. This

predominance of the male sex in childhood is of interest. Of the 158 cases of laparotomy for typhoid perforation collected by Keen,¹⁷ 84 per cent. occurred in males. According to Osler,¹⁸ males and females are about equally susceptible to typhoid fever, but male patients are more often admitted to hospitals. As most of the statistics are collected from hospitals, the predominance of perforation among the males can be partly, but not altogether, explained by the greater frequency that males apply to hospitals for treatment. The fact that 72 per cent. of the children with perforation were of the male sex cannot, however, be explained on the same basis.

General Symptoms.—Facies.—A decided change in the appearance of the face was noted in eleven of the twenty-five patients. In three, the facial appearance of the child remained unchanged for a considerable time after the appearance of other symptoms suggestive of perforation of the intestine. In ten patients no mention of the facies is made. The expression is described as pinched, anxious, collapsed. The change in the facial appearance never occurred early; it was usually observed after a number of other symptoms had directed attention to the possibility of perforation.

The primary shock of perforation is less evident in children than in adults. Children seldom show the sudden symptoms of collapse that are so frequent in adults. The pinched, anxious, collapsed appearance of the face appears only with the increasing infection of the peritoneum, and has only a proportionate value as a symptom of peritonitis.

Temperature.—In most of the cases the temperature curve showed nothing characteristic. The temperature either remained high or there were marked fluctuations. In four patients there was a sudden fall of temperature to the normal or subnormal at or soon after the perforation. Two of the patients had an intestinal haemorrhage just before the rupture of the bowel, so that the fall in the temperature was possibly due to the bleeding from the intestine.

Pulse.—In fifteen of the twenty-five cases, the pulse is described as having become more rapid and of poorer quality.

very soon after the occurrence of the perforation. In five patients the change was said to have been a sudden one at the time of perforation. In one patient (Case IX) there was no change in the character and frequency of the pulse between the time of perforation and the operation.

Respiration.—The changes in the frequency of the respiration were insignificant in all the patients until well-marked symptoms of peritonitis had developed.

Vomiting was present as an early symptom in only four patients. The longer, however, the delay in the operative interference, the more often did vomiting appear. In several patients there was no vomiting in spite of advanced peritonitis.

Leucocytosis.—Notes of leucocyte counts are given in only five cases. In five patients frequent leucocyte counts were made, and in all five there was a sudden or gradual increase in the number of white cells. The lowest count was 9000 and the highest 28,000. The fact that in all five cases a more or less marked leucocytosis was present might be considered significant, were it not for the fact that numerous cases have been reported in which there was no perforation, although abdominal symptoms and leucocytosis were present. Thus, McRae and Mitchell (*Johns Hopkins Hospital Reports*, Vol. x, Nos. 6-9) report two cases of this kind in children of twelve years of age. In one patient the symptoms were due to abdominal distention and the leucocyte count was 9700; in the second, the abdominal symptoms followed an intestinal haemorrhage and the leucocyte count was 12,000. Just before, and for a short time after, the perforation the number of leucocytes in the blood is probably always increased, but when infection of the peritoneal cavity begins there is a great outpouring of leucocytes into the peritoneum, and the number in the blood becomes rapidly diminished. If the leucocyte counts be made during the first period, a marked increase may be noted and may be of value as confirmative evidence, but the cases of McRae and Mitchell and others of the same kind show that the presence of a leucocytosis can be used only with circum-

spection as a diagnostic symptom, while the absence of a leucocytosis does not exclude the possibility of perforation.

Local Symptoms.—Pain.—In every case in which details are given (twenty of our series), the sudden appearance of pain is mentioned as the first symptom which called special attention to the abdomen. The pain was usually localized in the lower part of the abdomen, especially on the right side. In two patients the pain was limited to the right iliac region, in five others there was general abdominal pain. In most of the patients the pain occurred in paroxysms, in a few it was constant and varied little in degree.

Tenderness on palpation was present in every case, but there seems always to have been an appreciable interval between the first appearance of pain and the appearance of this abdominal tenderness. The abdomen was most tender in the right iliac region in six cases.

Appearance of the Abdomen.—Changes in the appearance of the abdomen were noted in all but three of the twenty-five patients. In three cases there was no abdominal distention. In nine patients there was "considerable" distention, in one patient the distention was "enormous." All the other patients had only a moderate degree of distention, no more than was often seen without perforation.

Rigidity of the abdominal muscles was more or less marked in fourteen patients.

Obliteration or well-marked diminution in the *area of liver-dulness* was noted in only five cases.

This short account of the main symptoms in the twenty-five cases of our series shows that there is no essential difference between the symptoms of perforation in children and in adults. Sudden pain or increase of the existing pain is generally the earliest and most prominent symptom, perhaps with abdominal tenderness and rigidity. Changes in the temperature and pulse, leucocytosis, vomiting, diminution in the area of liver-dulness, etc., have in most cases only confirmatory value. The collapsed appearance which is presented by many adults with typhoid perforation is rarely seen in children ex-

cept in the presence of advanced peritonitis. As a moderate amount of tympanites is more apt to be present during the entire course of the fever in the young, a slight increase in the distention may occur at any time without having any significance, and with this there may be a diminution of the area of liver-dulness due solely to the distention. In most cases it is not one or the other symptom, but the *ensemble* of symptoms which must lead to the diagnosis. When, in addition to the facts that have been mentioned above, we remember that children are not as well able to describe or localize their symptoms, it will be easily understood why the diagnosis of perforation is often exceedingly difficult, and why in children errors in diagnosis may the more easily occur.

A considerable number of cases have been reported which presented the so-called characteristic symptoms of perforative peritonitis but recovered without operation, and not a few cases have been published in which laparotomy was done and a peritonitis, but no perforation found. Peritonitis may occur with deep ulceration of the bowel and changes in the serous coat, but without perforation or other discoverable abdominal lesion. Cases of this kind have been reported by Cushing,¹⁹ Finney,²⁰ McRae and Mitchell,²¹ Herringham and Bowlby,²² and others. On the other hand, it cannot be denied (as was done by Henoch²³) that after typhoid perforation of the intestine recovery may take place without operation. The opening in the bowel may become closed by fibrin, by adhesions of omentum or other coils of intestine, or a localized abscess may form and be discharged through the bowel. Fitz,²⁴ Keen, and Murchison believed that 5 per cent. of the patients with perforation of the intestine in typhoid fever recover without operation. Fitz, however, says that "since suggestive, even so-called, characteristic symptoms may occur without any perforation having taken place, it must be admitted that recovery from such symptoms is no satisfactory evidence of recovery from perforation." Notwithstanding the obvious truth of the foregoing statement, it is certainly possible that recovery may take place without operation. During the past year the writer

had occasion to see a child that presented all of the characteristic symptoms of perforation in typhoid fever, in which permission for operation was refused, and which recovered without operation. For the kind permission to make use of the records of this case I am indebted to Dr. H. Koplik, Attending Physician to the Children's Service of Mount Sinai Hospital. The history of the case follows:

H. R., male, twelve years of age, was admitted to Mount Sinai Hospital on the children's service of Dr. Koplik on October 2, 1902. The boy was in the eleventh day of his typhoid fever, with a temperature of 103.8° F., a pulse of 106, and respirations of 26. The spleen was enlarged to percussion and palpation, the abdomen was slightly distended and tender. Leucocytes, 5000. There was a well marked Widal reaction in a dilution of 1 to 50.

For four weeks the disease ran the course of an attack of typhoid fever of a fair degree of severity. The temperature began to fall after the second week, and by October 24 reached the normal, or near the normal, every morning. Slight abdominal distention, tenderness, and rigidity persisted, but with the fall of the temperature became less marked. The leucocyte count varied between 6400 and 7000.

November 4. Forty-third day of the disease; child does not look as well as usual this morning.

November 4, 4 P.M. Temperature, 100.2° F.; pulse, 104; patient complains of severe abdominal pain, most marked in the umbilical region. The abdomen is generally tender, but the tenderness is most marked in the right iliac region; the abdomen is slightly distended, and the muscles are more rigid than they have been; leucocytes, 14,000.

4.30 P.M. The patient has vomited several times.

6 P.M. Temperature, 102° F.; pulse, 116 to 128; the abdominal pain has continued; physical examination of the abdomen is about the same as when last noted: on rectal examination, the right side of the pelvic cavity is distinctly more tender than the left; patient's general appearance is distinctly worse.

9 P.M. Temperature, 104° F.; pulse, 120 to 124; leucocytes, 13,000; patient is complaining of violent abdominal pain; liver-dulness not diminished; no dulness on percussion in the flanks.

November 5, A.M. Temperature, 103.8° F.; pulse, 124 to

130; respiration, 32; patient has not vomited for the past eighteen hours; abdominal pain persists with unabated severity; liver-dulness somewhat diminished; distention of abdomen slightly increased; right iliac fossa very tender on palpation; abdominal muscles very rigid.

3 P.M. Temperature and pulse still high; abdominal pain persists; area of liver-dulness considerably diminished; abdominal distention much more marked; entire abdomen extremely tender to palpation and percussion; slight dulness on percussion in both flanks; patient looks very badly and is somewhat cyanosed. At this time the patient was seen by Dr. Lilienthal, attending surgeon in consultation with Dr. Koplik. The diagnosis of perforation of the intestine was concurred in and immediate operation recommended, but permission for the operation was refused by the child's parents.

November 6, A.M. General condition poor; temperature, 104° F.; pulse, 140; heart sounds weak; abdomen more distended and very tender to percussion and palpation.

November 7. In the morning the patient still complained of much abdominal pain and the physical signs in the abdomen were unchanged. The patient had several voluntary fluid movements of the bowels. No vomiting. In the afternoon the pulse became less rapid and of better quality, and the abdomen was distinctly less tender and rigid and less distended. The tenderness was now most marked in the right iliac region, where there was a small area of localized dulness on percussion; leucocytes, 5800.

In the evening the abdomen was very much less tender and the patient's general condition very much improved; the temperature had dropped to 98° F. and the pulse to between 80 and 90.

November 8. Temperature, 98° to 100° F.; pulse, 70 to 86; respiration, 24 to 26; patient's condition is fairly good; he looks much better; the abdominal signs are very much less marked; there is now only slight tenderness in the right iliac region; pain is no longer complained of.

After this time the course of the disease presented nothing of special interest. For several weeks the leucocyte counts varied between 7000 and 13,000. All of the abdominal symptoms rapidly disappeared and convalescence was well established by December 1.

The patient was discharged cured on December 10.

In the opinion of every one who saw this patient, he presented all of the so-called characteristic symptoms of a sudden perforation of the intestine in the course of typhoid fever, and he would surely have been operated upon if permission for the laparotomy had been obtained. Every symptom and sign characteristic of perforation—marked abdominal pain, tenderness and rigidity, distention, diminution in the area of liver-dulness, dulness on percussion in the flanks, changed appearance of the face, rapid, poor pulse, vomiting, leucocytosis—were present. Although we must acknowledge that the only certain proof of perforation of the bowel would have been the demonstration of the same at an operation, we cannot but feel justified in considering the case one of perforation, and recovery without operation, on account of the presence of every symptom and sign which are considered typical and characteristic of perforation. It is possible that the case was one of perforation of an ulcer of the appendix—that is, of so-called typhoid appendicitis,—an affection in which the tendency to localization of the process and spontaneous resolution is much greater than in perforation of the small intestine.

Time of Perforation.—The perforation occurred during the first week in no cases; second week, in 2 cases; third week, in 10 cases; fourth week, in 2 cases; fifth week, in 3 cases; sixth week, in 3 cases; a relapse in 4 cases; (?) in 1 case.

Perforation took place, therefore, most often during the third week and during a relapse. One of the cases noted above as having occurred during the third week was reported as having taken place “some time during the second or third week.”¹⁰ While the physician who treats a case of typhoid fever in a child should always be on the lookout for abdominal symptoms, it is more especially during the third week of the disease and during a relapse that this abdominal complication is apt to occur. The abdomen should be frequently examined, and even the seemingly most trivial changes noted. If there has been diarrhoea or well-marked tympanites throughout the disease, or if the patient has had an intestinal haemorrhage, no matter how small in amount, there is a much greater chance

of perforation. The conditions just mentioned are more apt to occur with deep ulceration of the bowel, and their presence is generally an evidence of the severity of the intestinal lesions.

The Time of Operation.—The shortest interval between the first symptoms of perforation and the operation was two hours (Case XX); the longest, nine days (Case XVI).

The operation was performed during the first 4 hours in 2 cases, 100 per cent recoveries; during the second 4 hours in 3 cases, 2 recoveries, 66.7 per cent. recoveries; during the third 4 hours in 7 cases, 5 recoveries, 71.4 per cent. recoveries; during the fourth 4 hours in 3 cases, 3 recoveries, 100 per cent. recoveries; during the fifth 4 hours in 1 case, 0 recoveries, 0 per cent. recoveries; during the sixth 4 hours in 1 case, 0 recoveries, 0 per cent. recoveries; later than first 24 hours in 7 cases, 4 recoveries, 57 per cent. recoveries; (?) in 1 case, 0 recoveries, 0 per cent. recoveries.

The Prognosis in Children.—While a statistical table of twenty-five cases is a small one from which to draw any sweeping conclusions, the above table does seem to indicate that very early operative interference offers the best chance for recovery. Two patients operated upon during the first four hours recovered. One patient, among three who were operated on during the second four hours after the first symptoms of perforation, recovered from the operation and from all of the abdominal symptoms, but died one week later from typhoid toxæmia (Case XXI). If this case be considered an operative recovery, then all five cases operated on during the first eight hours recovered, and of fifteen patients operated on within the first sixteen hours, thirteen, or 86.6 per cent., recovered. Of nine patients operated upon after the first sixteen hours had elapsed, only four, or 44.4 per cent., recovered.

Keen, Loison,²⁵ and others have made some allusion to the fact that after operative interference for typhoid perforation, the prognosis is more favorable in children than in adults, but comparative statistics have never yet been made. The operative reports of different surgeons show that children

recover more often than adults. Thus, Taylor²⁶ operated upon five patients,—four adults and one child,—and only the child recovered; Dalziel²⁷ operated on five adults and one child, and only the child recovered; Escher²⁸ operated upon two children and two adults, both children and one adult recovered. Among the 289 operations for typhoid perforation of the intestine collected by the writer, twenty-five were in children with sixteen, or 64 per cent., recoveries. The statistics are the following:

Total number of cases operated on, 289.

Total number of patients recovered, 75; 25.9 per cent.

Total number of patients died, 214; 74.1 per cent.

Total number of adults, 264; 91.4 per cent.

Total number of children, 25; 8.6 per cent.

Total number of adults recovered, 59; 22.4 per cent. of the adults.

Total number of adults died, 205; 77.6 per cent. of the adults.

Total number of children recovered, 16; 64.0 per cent. of the children.

Total number of children died, 9; 36.0 per cent. of the children.

Therefore, twenty-five, or 8.6 per cent. of the operations that have been performed, were in children, with a mortality of only 36 per cent., while 264, or 91.4 per cent. of the total number of operations, were done in adults with a mortality of 77.6 per cent. The chances of recovery are therefore more than twice as good in children as in adults.

These statistics show that the prognosis after operations for typhoid perforation in children is far better than has been believed heretofore. As good results as the above can surely never be obtained by medical treatment alone, or by delay in operative interference with the hope that or until the inflammatory process has become localized. The treatment of perforation of the intestine—no matter from what cause—will in all probability always retain its surgical character; and I doubt that perforation of the bowel in the course of typhoid fever will

be an exception to this rule. Surgically speaking, we believe with Cushing that the only positive contraindication to the operation is a moribund condition of the patient. Much depends upon an early diagnosis, and further improvement in operative results will surely follow advances in diagnostic methods.

Operation.—The most important point to be kept in mind in the consideration of the operative methods for typhoid perforation is that rapidity is necessary for successful results. Children bear operations upon the abdomen as well as, if not better than, adults, if the manipulations be not too much prolonged. Mauger²⁹ declares that a laparotomy for typhoid perforation should never take more time than thirty minutes, and that the operation should never be undertaken by any one who is not sure of his technique. Although some patients have recovered after operations which lasted for one hour or over, it is nevertheless true that every increase in the duration of the operation diminishes by considerable the chances of recovery of the patient. As an example of what some children with typhoid perforation are able to withstand, we might cite the case reported by Cushing (Case XIII) in which the patient was operated on three times within two weeks—twice for perforations and the third time for intestinal obstruction from adhesions—and recovered.

Regarding the technical details of the operation in children, little need be said, as the operative measures are the same as for adults. I believe, however, that a light chloroform anaesthesia is preferable to local anaesthesia in children. Aside from the difficulty of keeping children quiet during operations under local anaesthesia, my experience in other abdominal operations in children has led me to believe that in children there is less danger of shock after operations under chloroform than under local anaesthesia, no matter how much morphine the patient has received before the operation.

The abdominal incision should preferably be made along the outer border of the right rectus muscle (Kammerer) or through its fibres, as in most cases the lesion will be found on

the right side of the abdominal cavity. In children, the greater part of the peritoneal cavity can often be examined through this incision.

In children, the infiltration of the wall of the bowel around the perforation is seldom so extensive as to prevent the closure of the opening in the intestine by a double layer of Lembert sutures. These had best be passed in the long axis of the bowel, so that, when tied, they will cause a minimum amount of constriction of the intestinal lumen. If the perforation be so large or the infiltration of the wall of the bowel so extensive that simple suture is impossible, the best procedure will be an omentoplasty. A portion of the omentum is sewed over the opening in the bowel, and escape of intestinal contents thus prevented. Resection of the intestine should never be done if it can possibly be avoided; very few patients would bear the additional shock of an intestinal resection. Resection of the bowel for typhoid perforation has, however, once been performed in a child with recovery (Case II).

Escher³⁰ has recently recommended that the perforation in the bowel wall should not be sutured, but that the affected loop of intestine should be sewn to the edges of the incision in the abdominal wall and the bowel drained. Of four patients operated on by this method three recovered. Escher claims three advantages for his method: (1) the rapidity with which the operation can be done; (2) the prevention of paralytic ileus by drainage of the intestine; (3) favorable effect upon the peritonitis of drainage of the intestine. I do not believe that the first advantage claimed by Escher is of importance. The difference in the length of time that is required for the suture of a perforation and for the attachment of a loop of the bowel to the abdominal wall will in most cases be a very small one. The beneficial effects of drainage of the intestine upon paralytic ileus and peritonitis cannot, however, be denied. I believe that this method of treatment proposed by Escher merits serious consideration. It is well worthy of a trial in an appropriate case where the perforation is of large size and situ-

ated low down in the ileum, and where there is already present an advanced stage of peritonitis.

In the majority of cases (82.6 per cent., Loison³¹) there is only one perforation, but a careful search for other perforations should always be made. Monod and Vanverts³² state that it is sufficient to examine the intestine for a distance of fifty centimetres above the location of the perforation, but at least three to four feet of the ileum and in some cases the ascending colon and appendix vermiciformis should be examined.

Whether the peritoneal cavity should be washed out with saline solution or not is a question whose answer must be left to the individual operator, who will be guided by his own views on the subject of irrigation of the peritoneal cavity in diffuse peritonitis. My own experience in abdominal surgery in children has been that unless there is distinctly faecal matter in the peritoneal cavity, the peritoneum will take care of itself and irrigation be unnecessary. Up to the present time very few reports of the bacteriological findings in peritonitis after typhoid perforation have been published, but it is highly probable that, from the clinical stand-point at least, the peritonitis does not differ essentially from the peritonitis that follows perforation of the bowel in other diseases. I prefer to sponge away as much as possible of the exudate with gauze sponges and to depend to a great extent upon the absorptive powers of the peritoneum. Where, however, there is faecal matter in the abdominal cavity, irrigation with isotonic 0.9 per cent. saline solution is necessary. Great care should be taken to keep the intestines as much within the abdominal cavity as possible, for the shock of evisceration in children is very great.

Neither do I think there is any advantage in a wide drainage of the peritoneal cavity. It will generally suffice to pass a small strip of gauze or a cigarette drain down to the suture line in the intestine and then to close the greater part of the abdominal incision. In the large number of cases of perforative appendicitis with diffuse peritonitis that we see at Mount Sinai Hospital every year, we rarely attempt to drain the general peritoneal cavity widely, because we do not believe that

a wide drainage of the peritoneal cavity can often be accomplished. Within a few hours of the insertion of the drains the general cavity becomes walled off by adhesions around the drains. From the time that we stopped draining the peritoneal cavity widely, or rather making the attempt to do so, our results in peritonitis have become distinctly better (see Mount Sinai Hospital Reports, Vol. iii, report of the Second Surgical Division of Dr. Howard Lilienthal).

The after-treatment differs in no way from that after laparotomy for other conditions, with the exception that the general feeding must be that of a patient with typhoid fever.

. CONCLUSIONS.

Although the writer is well aware of the fallibility of statistics,—successes being more often published than failures,—the chances of error are much less where comparative statistics are given. Although it is very probable that the mortality after laparotomy for typhoid perforation is somewhat greater than the statistics show, there is no reason to doubt that the prognosis in children is fairly good,—more than again as good as in adults.

The figures given in this paper refer to children between the ages of six and fifteen years, and not to younger children or infants in whom perforation is very rare, and in whom no operation for typhoid perforation of the intestine has been recorded in literature.

The advances in abdominal surgery have been so great since Mikulicz's first operation for perforation of the intestine, that the profession is to-day almost unanimous in the belief that the only treatment for perforation of the bowel in the course of typhoid fever—as soon as the diagnosis has been made—is a surgical one. It may be many years before we can hope for much improvement in the surgical methods of treatment of diffuse peritonitis. The operative results will, however, become better if the patients are referred to the surgeon more early. Improvement can therefore only come with improved methods of diagnosis. It is from this point of view

that efforts—such as that of Cushing and his suggestion of a preperforative stage—are of value. While we may not agree with Cushing as to the possibility of diagnostinating the condition correctly in any more than exceptional cases, the effort is certainly one in the right direction.

In this paper the attempt has been made to show

(1) That perforation of the intestine in the course of typhoid fever is very nearly as frequent in children between the ages of six and fifteen years as in adults.

(2) The symptoms do not differ essentially from those of adults.

(3) Although recovery may, in exceptional cases, take place without operation, the treatment should be a surgical one as soon as the diagnosis has been made.

(4) The prognosis after operation is more than twice as good in children as in adults, and very early operative interference offers the best chances for recovery.

TABLE OF CASES OF LAPAROTOMY FOR TYPHOID PERFORATION IN CHILDREN.

No.	Author.	Sex.	Age.	Main Symptoms.	Day of Disease.	From First Symptom to Operation.	Laeoco- stic.	Result.	Remarks.
1	Alexandoff ³³	M.	9	Sudden pain ; vomiting ; rapid pulse.	35th day.	20 hours.	.....	Death, $\frac{1}{2}$ hour. Recovery.	Chloroform anesthesia ; general purulent peritonitis.
2	W. Hill ³⁴	M.	13	.....	6th week.	12 hours.	.....	Large perforation ; resection and Murphy-button anastomosis.	
3	Brun ³⁵	M.	14	Sudden pain ; early and continued vomiting ; moderate distention ; general tenderness and rigidity ; rapid pulse ; pinched face.	In re-lapse.	22 hours.	.....	Death, 7th day.	Perforation sutured ; irrigation ; at autopsy five other perforations ; general peritonitis.
4	Léjas ³⁶	M.	11	Symptoms of peritonitis.	?	?	.....	Death.	
5	Hawkins and Thurston ³⁷	F.	11	Sudden pain, in attacks ; general tenderness and rigidity ; vomiting ; no distention.	41st day.	15 hours.	.....	Recovery.	In irrigation ; drainage ; excision of perforation and suture ; perforation in cecal wall ; seropurulent fluid.
6	Dalziel ³⁸	F.	13	.....	4th week.	11 hours.	.....	Recovery.	Median incision ; irrigation ; drainage.
7	Finney ³⁹	M.	12	Sudden pain ; distension ; tenderness and rigidity ; rapid pulse.	2d-3d week.	3 days.	.....	Death.	Abdominal cavity contained gas, pus, and feces ; suture of perforation ; irrigation ; drainage ; entered hospital in extremis.
8	Martin ⁴⁰	M.	12	.....	3d week.	33 hours.	.....	Death, 16 hours post op. Recovery.	General purulent peritonitis ; suture of perforation ; irrigation ; drainage.
9	C. R. Russell ⁴¹	M.	7	Gradual onset of pain and abdominal tenderness ; no distention or rigidity ; vomited once.	10th day.	12 hours.	28,000	.....
10	Legueu ⁴²	?	10	Sudden pain in right iliac fossa, with rigidity and tenderness ; small pulse.	15th day.	12 hours.	.....	Death.	
11	Legueu ⁴²	M.	15	Sudden pain ; collapse.	20th day.	6 hours.	.....	Recovery.	Large perforation ; purulent fluid in cavity ; omentoplasty ; drainage.

TABLE OF CASES OF LAPAROTOMY FOR TYPHOID PERFORATION IN CHILDREN.—Continued.

No.	Author.	Sex.	Age.	Main Symptoms.	Day of Disease.	From First Symptom to Operation.	Leuco-cytes.	Result.	Remarks.
12	A. A. Berg ⁴³	M.	7	Sudden pain in right iliac region; chills, fever, vomiting; abdominal distention; tenderness, rigidity.	2d week.	22 hours.	.....	Recovery.	Ambulatory typhoid; diffuse peritonitis; suture of small perforation; no irrigation; drainage.
13	Cushing ⁴⁴	M.	9	Colicky abdominal pain, vomiting, rapid feeble pulse, high temperature, cyanosis, abdominal tenderness.	13th day.	4 hours.	16,000	Recovery.	Suture of perforation; seropurulent fluid in general peritoneal cavity; irrigation; drainage; fecal fistula from second perforation. Twelve days later laparotomy for symptoms of perforation; none found. Two days later laparotomy for acute intestinal obstruction due to adhesions about another perforation.
14	Richards and Goodall ⁴⁵	F.	8	Very gradual onset, with abdominal pain and tenderness.	Relapse.	12 hours.	.....	Death in 4 days.	Perforation thirty inches from cecum; suture, irrigation, drainage; autopsy showed another perforation.
15	Hugh M. Taylor ⁴⁶	M.	9	Sudden colicky pain, with abdominal tenderness and rigidity on right side; some vomiting; no distention.	Relapse.	15 hours.	.....	Recovery.	Seropurulent peritonitis; perforation sutured; irrigation; drainage.
16	Pearson ⁴⁷	M.	14	Sudden abdominal pain, followed by symptoms of peritonitis.	16th day.	9 days.	.....	Recovery.	Abscess opened and drained.
17	W. L. Rodman ⁴⁸ .	F.	12	Sudden pain, followed by chill and collapse. Temp. dropped to 96.2° F., from 105°; later rose to 102°; marked distension and tenderness; repeated vomiting; anxious look.	5th week.	37 hours.	Recovery.	Intestines distended; perforation size of end of finger; suture; irrigation; drainage.

CHILDREN.—Continued.

PERFORATION OF INTESTINE IN TYPHOID.

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TABLE OF CASES OF LAPAROTOMY FOR TYPHOID PERFORATION IN CHILDREN.

No.	Author.	Sex.	Age.	Main Symptoms.	Day of Disease.	From First Symptom to Operation.	Leuco-cytes.	Result.	Remarks.
18	Dandridge ¹⁹	M.	9	Sudden severe pain, with increasing distention of liver; chill; obliteration of rapid, dullness; pinched face; rapid, small pulse.	21st day.	3 days.	.....	Recovery.	Gas and stinking pus in peritoneal cavity; irrigation; drainage.
19	Dandridge ¹⁹	M.	10	Vomiting first symptom; abdominal distention and tenderness. Sudden pain; marked tenderness; some distention; marked stiffness; no vomiting; liver-rigidity; no obliterated; dullness somewhat obliterated; dullness, somewhat pulse.	21st day.	28 hours.	.....	Death.	Diffuse peritonitis; perforation one inch from cæcum; suture; irrigation; ten centimetres from cæcum; omentoplasty; irrigation; drainage.
20	McRae and Mitchell ¹⁵	F.	8	Rapid, weak pulse. Pain in paroxysms; ten-sudden pain, rigidity, ten-later, distention, partial obliteration of liver-dullness.	19th day.	8 hours.	1,500	Recovery.	Death due to toxæmia of the disease after all abdominal symptoms had disappeared.
21	McRae and Mitchell ¹⁵	M.	11	Paroxysm of severe pain in abdomen, followed by sweating, abdominal rigidity; rapid and feeble pulse.	30th day.	8 hours.	12,000	Death after one week.	Gas and fluid in cavity; two feet distended; perforation; suture from valve; no irrigation.
22	Rowley ⁵⁰	M.	10	Sudden fall of temp. to subnormal, with distention of abdomen, followed by abdominal tenderness, vomiting.	34th day.	2 hours.	.....	Recovery.	Perforation not found; fecal fistula established. Perforations in lower part of ileum; drainages purulent peritonitis; no suture.
23	Fischer ⁵¹	M.	8	Sudden pain, followed by symptoms of general peritonitis. Chill, followed, tenderness, rigidity, pain; partial obliteration of liver dullness; vomiting.	4th week.	80 hours.	.....	Recovery.	Perforations twenty centimetres from valve; aeropurulent peritonitis; perforation sutured; no irrigation.
24	Fischer ⁵¹	M.	6½	Chill, followed, tenderness, rigidity, pain; partial obliteration of liver dullness; vomiting.	3d week.	10 hours.	.....	Recovery.	Perforation sutured. Drainage.
25	Wiberg	M.	.....	.....	16 hours.	18,000	Recovery.	.....	.....

CASES OF LAPAROTOMY FOR TYPHOID PERFORATION IN
ADULTS FROM JANUARY, 1900, TO MARCH, 1903.

- Woolsey, *ANNALS OF SURGERY*, 1900, p. 764, 1 death.
 Jones, *ANNALS OF SURGERY*, Vol. xxxiv, p. 177, 1 recovery.
 Cushing, *ANNALS OF SURGERY*, 1901, 1 recovery.
 Russell, *Boston Medical and Surgical Journal*, Vol. cxliv, No. 16, 1 death.
 Lower, *Cleveland Medical Gazette*, 1900, p. 321, 1 death.
 Armstrong, *Journal of the American Medical Association*, May, 31, 1902,
 25 deaths, 1 recovery.
 Briggs, *American Journal of the Medical Sciences*, January, 1902, 4 deaths,
 1 recovery.
 Houchard, *Bull. et Mém. de la Soc. Anat.*, April, 1899, 1 death.
 Mayer, *Pennsylvania Medical Journal*, 1900, 1 recovery.
 Dans, *Presse Médicale*, December, 1900, 1 recovery.
 Legueu, *Revue de Chirurgie*, December, 1900, 1 recovery.
 Warren, *Transactions of the American Surgical Association*, Vol. xviii,
 1900, 19 deaths, 3 recoveries.
 Loison, *Revue de Chirurgie*, xxiii, 1901, 1 recovery.
 Legueu, *Revue de Chirurgie*, xxiii, 1901, 2 recoveries.
 Rochard, *Revue de Chirurgie*, xxiii, 1901, 2 deaths.
 Routier, *Revue de Chirurgie*, xxiii, 1901, 1 death.
 Shoemaker, *Medical News*, April 12, 1902, 1 death.
 Taylor, *Dublin Journal of the Medical Sciences*, January, 1901, 2 deaths.
 Loison, *Revue de Chirurgie*, 1900, p. 179: Sieur, 1 death; Mignon, 1
 death; Davis, 1 death.
 Monod, *Bull. de la Soc. de Chir.*, December, 1900, 1 death.
 D'Audet, *Arch. de Méd. Militaire*, 1899, Vol. xxiv (see Loison), 2 deaths.
 Platt, *British Medical Journal*, 1899, p. 1097, 2 deaths, 1 recovery.
 Borrs, *British Medical Journal*, 1900, 1 death.
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 Deanesly, *British Medical Journal*, May 4, 1901, 1 recovery.
 Heuston, *British Medical Journal*, November 16, 1901, 1 recovery.
 Marsden, *Lancet*, June 23, 1900, 1 death.
 Godwin, *Lancet*, August 17, 1901, 1 death.
 Davis, *American Medicine*, January 18, 1902, 1 recovery.
 Willard, *ANNALS OF SURGERY*, Vol. xxix, p. 503, 1 death.
 Taylor, *Virginia Semimonthly Medical*, 1899, 4 deaths.
 Dandridge, *Cincinnati Lancet Clinic*, 1901, 1 death.
 J. C. Munro, *Boston Medical and Surgical Journal*, February 5, 1903, 14
 deaths, 1 recovery.
 Ferrier, *Semaine Médicale*, 1901, No. 7, 2 deaths, 1 recovery.
 F. Tilden Brown, *ANNALS OF SURGERY*, March, 1903, 2 deaths, 1 recovery.
 Escher, *Grenzgebiet der Medicin und Chirurgie*, Vol. xi, No. 1, 1 death,
 1 recovery.
 Hays, *American Medicine*, September 6, 1902, 4 deaths, 3 recoveries.
 See also *Therapeutische Monatshefte*, November and December, 1902, for
 additional cases.

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³ Transactions of Association of American Physicians, 1891.
⁴ The Diseases of Infancy and Childhood.
⁵ Handbuch der Kinderkrankheiten.
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¹¹ Nothnagel's System, American Edition, Vol. i.
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¹³ Johns Hopkins Hospital Reports, 1900.
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⁴² Cited by Léjars, Bull. et Mém. de la Soc. de Chir. de Paris, 1900, p. 1156.
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⁴⁹ *Cincinnati Lancet Clinic*, 1901, p. 577.

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DISLOCATION OF THE CARPAL SCAPHOID.

BY LEONARD W. ELY, M.D.,
OF NEW YORK.

DISLOCATION of the scaphoid bone of the wrist, without fracture, is a very rare injury. In his book on fractures and dislocations, Stimson gives only two authenticated cases. Fracture of the scaphoid, with dislocation, is also rare. According to the same writer, there are only five cases on record.*

The history of this case is as follows: On the 1st of February, 1903, an automobile in which the patient, a man of twenty-five, was riding, overturned, and, as far as could be learned, some part of it fell on his right wrist. The lesion was diagnosed as crushing of the tendons of the wrist, and hot applications were prescribed. These were continued for about twenty-four hours. When seen next morning for the first time, the wrist was swollen and infiltrated, and presented on its flexor aspect a number of abrasions, showing the nature of the violence—that is, direct. Motion or pressure caused pain. The case appeared to be a Colles's fracture, and the patient was told that he must take an anaesthetic and have it reduced. The operation was done that afternoon.

Under ether, crepitus could be distinctly perceived in the wrist, though its origin could not be exactly ascertained. By manipulation, the scaphoid could easily be dislocated on the dorsum of the wrist, and by pressure could be replaced. On this symptom the diagnosis was made. The skiagram taken at a later date shows a slight tipping forward of the scaphoid, and a chipping off of the styloid process of the ulna; but we shall remain in doubt whether the lesion was a simple dislocation of the scaphoid, or whether it was accompanied by a fracture of this or of one of the neighboring bones. The skiagram showed no such fracture, but the crepitus seemed to come from a point very near the scaphoid. The dislocation, however, was unmistakable.

* ANNALS OF SURGERY, vol. XXXV, p. 257.

The treatment was by anterior and posterior molded plaster-of-Paris splints, the posterior splint reaching to the end phalanges, the anterior to the metacarpophalangeal joints. At the end of one week the anterior splint was removed, and at the end of about three weeks the posterior splint was taken off, and adhesive tape was applied to the forearm and hand. This was left on for about two weeks, permitting some motion, but affording a certain amount of support.

The patient recovered with a good degree of motion in all directions.

In Stimson's two cases of fracture, he made his diagnosis sure by cutting down and excising the misplaced fragments. The displacement in our case was not sufficient to warrant this, and the wounds on the anterior surface, being mere abrasions, did not necessitate a cutting operation.

The injury is a rare one, but our experience leads us to think that it may occur without recognition. If we had not used an anæsthetic, the nature of the injury would probably have escaped us, for only when the muscles were completely relaxed by the ether could the scaphoid be moved about. Perhaps Colles's fracture bears some blame it does not deserve, and crushing of the tendons at the wrist might be thought to cause great disability and deformity.

[The writer acknowledges his indebtedness for assistance to Dr. William C. Clarke, who was the first to recognize the true nature of the injury.]

Dislocation of the carpal scaphoid



TRANSACTIONS
OF THE
NEW YORK SURGICAL SOCIETY.

Stated Meeting, March 11, 1903.

The President, LUCIUS W. HOTCHKISS, M.D., in the Chair.

UNUNITED FRACTURE OF CLAVICLE TREATED BY SUTURE.

DR. ALEXANDER B. JOHNSON presented a young man of twenty-two years, who entered hospital September 8, 1901. About a year previous to that date he had received an injury to his right shoulder, for which no treatment had been sought. The shoulder became painful, and he could bear but little weight upon it. Examination revealed a fracture of the right clavicle near the middle with weak fibrous union, with marked overriding. The lower fragment was displaced backward and there was great disability. Upon exposing the fracture, it was found to be extremely difficult to approximate the two ends of the bone. In order to accomplish this, so much force was necessary that it was thought wiser to remove a small section of bone from each fragment. After the removal of these shelf-like sections, forming a mortise, the two fragments were approximated and sutured with heavy catgut. The patient remained in the hospital about three weeks. Good bony union was evidently secured, as there were no evidences of motility at the present time. The limb was useful and strong.

TORSION OF THE OMENTUM.

DR. JOSEPH A. BLAKE presented a man, forty-five years old, a book-keeper by occupation, who was admitted to Roosevelt Hospital January 5 of the present year with the following history.

He had had an inguinal hernia on the right side for twenty years, which had always been reducible, and for which he had worn a truss at times, but not continuously.

Three days before his admission he had had pain in the right side of the abdomen and in the hernia. Attempts at reduction were unsuccessful and attended with pain. The pain increased and was located chiefly in the epigastrium and right side of the abdomen. There was also nausea and some vomiting.

The condition on admission was as follows: Italian; short stature; obese; evidently suffering from severe pain; general condition fair; temperature, 101° F.; pulse, 100. Panniculus very thick. A large scrotal hernia on the right side, which was not tense, but extremely tender. A small part of the contents could be reduced, showing that the canal was not wholly occluded; the remainder was apparently irreducible omentum. The lower right quadrant of the abdomen seemed to be filled with a mass which reached to the middle line; the muscles were rigid and, on account of the thickness of the abdominal wall, the mass could not be defined.

As the patient was excitable and spoke only a little English, a reliable history could not be obtained at that time, and the true nature of his difficulty was not suspected.

A diagnosis of probable appendicitis with a peritonitis spreading into the hernial sac was made. An incision was accordingly made through the right rectus. The omentum was found directly beneath the wound and was completely gangrenous. Its bulk was not increased, so that the arterial supply must have been cut off as soon as the venous return. Its lower end entered the neck of the hernia and could not be withdrawn.

The abdomen contained a slight amount of bloody serum. A second incision was then made over the inguinal canal and the sac isolated and opened. It contained some bloody serum. Two fingers could be easily inserted alongside the omentum through the internal ring, showing that there was no constriction. The omentum was then pushed through into the abdomen with some difficulty. It was not adherent to the sac, but its extremity was thickened.

The omentum could then be brought out of the abdominal wound, and it was found twisted through four and a half turns at its attachment to the transverse colon, constricting it to a rope-like mass one and one-quarter inches in thickness and four inches long.

The entire gangrenous portion was removed, and when spread

out measured twenty-three inches in length and fourteen in breadth. It weighed two pounds and twelve ounces.

The abdominal cavity was washed out, the wound closed, and a radical operation performed on the hernia. No drainage was employed.

The wounds healed *per primam*, and the patient was discharged in three weeks.

The mechanism in this case differs to a certain extent from that in the reported cases.

The sequence of events was probably as follows. The circulation of the omentum in the sac became temporarily obstructed, rendering it irreducible. The attempts at reduction probably started the torsion, which was then carried on by repeated attempts at reduction or by the muscular action at the ring.

In all but one of the cases collected by Wiener, who published them with one of his own in the ANNALS OF SURGERY of November, 1900, the tip of the omentum was adherent, causing a more or less sling-like arrangement. In this case the end was not adherent, but was retained in the hernial sac.

Wiener, in a very careful search, was only able to find seven cases, including his own.

In all cases a hernia was present, but the omentum was not always found in relation with the hernia.

In none of the cases was so much of the omentum involved as in this case.

DR. CHARLES H. PECK said he had seen a similar case four years ago. The patient was a woman, thirty-seven years old, who, when she entered the hospital, gave an acute history of about one week's duration. She had a slight temperature, less than 102° F.; there was some abdominal pain, and the entire lower abdomen, especially on the right side, was distinctly rigid. Through the vagina a bulging mass could be felt behind the cervix. The case was regarded as one of suppurating cyst, but, upon attempting to evacuate it through the posterior fornix, it proved to be a solid mass. That wound was thereupon packed, and upon opening the abdomen an omental torsion was found which filled the entire lower abdomen. The pedicle was quite large, about the same size as that in the case reported by Dr. Blake. The omentum was in a gangrenous condition. The entire mass was removed without much difficulty, as the adhesions were very recent, and the patient

made an uneventful recovery. She gave a history of a right inguinal hernia of twelve years' duration, for which she had never worn a truss, and which had never before given her any trouble.

INTESTINAL OBSTRUCTION.

DR. WILLY MEYER presented a woman, thirty-eight years old, who, when she came under his observation, September 26, 1902, stated that four weeks before she had a sudden abdominal pain in the left inguinal region. This improved under treatment. A week later she had another attack of intense pain in the same region, and from that time on she complained of intermittent, loud, gurgling abdominal sounds day and night. Her appetite had been good; there had been no vomiting. The last movement of the bowels had been four days before; since then there had been absolute obstruction.

When Dr. Meyer first saw the patient she was up and about and suffering no pain. Her pulse was 96; temperature normal. Fæcal vomiting had set in that morning. The abdomen was tympanitic, and the loud, gurgling sounds referred to above were heard once in the course of the examination. Upon auscultation, peristaltic noise was audible. There was slight, generalized tenderness over the entire abdomen. In the posterior lip of the cervix a hard, irregular nodule was felt, which had been diagnosed by her attending physician as a myoma. Malignancy of this tumor was suspected.

Immediate operation at the German Hospital September 26, 1902. After previous lavage of the stomach and thoroughly cleansing the vagina, a median abdominal incision was made. Through this a large quantity of serous fluid escaped. Both the small and large intestines were immensely distended; they were rapidly eviscerated, and the incision was lengthened to a point midway between the umbilicus and xiphoid. At the junction of the sigmoid and rectum a cancerous mass was found tightly constricting the gut. Both ovaries and tubes were also involved in the shape of large tumors; and upon removing these it was seen that the whole lower portion of the rectum, as well as the peritoneum of the small pelvis, was studded with carcinomatous deposits. The trouble was so extensive that only a palliative operation was deemed justifiable. This consisted of an inguinal colostomy, with a spur formation, which was done through the usual

incision. The gut having been sutured in place, an attempt was made to replace the intestines within the peritoneal cavity; they had been out for nearly an hour, and were black and blue. As reduction was impossible, a transverse incision was made into a knuckle of small intestine, and through this a large amount of foul-smelling faecal matter escaped. She had also vomited considerable faecal matter during the course of the operation. As she had been kept in Trendelenburg's posture, aspiration was avoided. After emptying the intestines, it was a comparatively easy matter to replace them, with the help of "Kümmel's serviette." At this juncture the patient was given an intravenous infusion. Now the upper and lower ends of the wound were stitched, the rest left open with secondary sutures in place. The spur was then incised transversely, just long enough to admit a large drainage tube, and the patient was put to bed.

There was free drainage from the partially open abdominal wound, and on October 1, five days after the primary operation, the patient was again put under a general anæsthetic, and the abdominal wound was closed. A further transverse slit was also made in the artificial anus, and the borders of the sigmoid were stitched to the skin by silkworm-gut sutures. In the following night the patient became seriously sick, her temperature rising to over 106° F., pulse to 160. With careful nursing she pulled through.

With the exception of the development of a bed-sore over the sacral region, which appeared within a few hours and went soon to the bone, the patient made a good recovery from the operation, and since then she has gained over twenty-five pounds in weight. A microscopical examination of the growth confirmed the diagnosis of carcinoma.

Dr. Meyer said that in cases of incomplete intestinal obstruction of long standing, with great distention of the abdomen (obstructive ileus) in old people, he was strongly in favor of a primary colostomy. If possible, he would in such cases henceforth use the appendix, after the method suggested by Dr. Weir, for the purpose of emptying the distended intestines, provided the organ proved to have sufficient caliber. Such operation (intermuscular) could be well done under local cocaine anæsthesia.

DR. GEORGE WOOLSEY said he did not think it would always prove feasible to employ the appendix for the purpose mentioned by Dr. Meyer. In old people, especially, there was a tendency

for the appendix to atrophy, and in 50 per cent. of cases over sixty years its lumen was partly obliterated, so that it was doubtful whether its lumen would be large enough to serve as an outlet for the faeces.

DR. MEYER, in reply to Dr. Woolsey, said that in old patients, who were in no condition to bear a prolonged operation or a general anaesthetic, it might be worth the trial to empty the distended intestines through the appendix. That operation was comparatively simple, and could be done under a local anaesthetic. The distended gut was opened after the abdominal cavity had been closed. Even if the lumen of the appendix was somewhat small, it might afford an exit for the thin contents of the gut.

CICATRICIAL STRICTURE OF THE OESOPHAGUS (ABBE'S STRING METHOD).

DR. MEYER presented a boy, five years old, who, in March, 1901, drank caustic lye from a bottle. As a result of this, he subsequently developed two strictures of the oesophagus,—the one five and the other nine and one-half inches from the teeth. At first, small-sized bougies could be introduced into the stomach, but, because of an intercurrent attack of tonsillitis, the treatment had to be discontinued; and upon his recovery it was found that not even the smallest-sized instrument would pass the obstructions. A gastrostomy (Kader) was thereupon done at the German Hospital, and about a month later a small filiform bougie could again be introduced from above. Repeated attempts were then made, with the aid of the cystoscope and various curved and straight forceps, to locate and grasp the lower end of the bougie through the gastrostomy wound, but these proved fruitless until the stomach had been filled with fluid. It was then easily caught with the forceps, and a piece of stout fish-line attached, which was drawn upward through the mouth. A few days later, by the sawing method described by Dr. Abbe, the two strictures were gradually divided until a No. 35 French bougie could be passed without difficulty. The instruments devised by Dr. Theodore Dunham were used with great success, the doctor himself kindly aiding at the operation. One week later the manœuvre was repeated. Since then the caliber of the oesophagus has been maintained by means of Dunham's instruments. The gastrostomy wound was

allowed to close. The little patient is now in excellent condition, eats what he wants, and swallows without any difficulty. He has materially gained in weight.

DR. BLAKE said that about two years ago he employed Dr. Dunham's method in a case of impervious stricture of the oesophagus in an adult. In that instance, no instrument could be made to pass the point of stricture, but by the thread-swallowing method, as demonstrated by Dr. Dunham at a meeting of the Surgical Society about a year ago, the result of the treatment was highly satisfactory.

DR. WOOLSEY said that the result of dividing an oesophageal stricture by the Abbe string-saw method was usually successful and devoid of danger. In a paper read in 1894 (*ANNALS OF SURGERY*, March, 1895) he collected twenty-eight cases of operation for cicatricial oesophageal stricture without a death. About a year ago he operated by this method upon a patient who was an alcoholic subject, and in whom the stricture was very low down, near the cardia. Through the opening in the stomach the oesophageal orifice could not be felt or found, but a small bougie introduced from above gradually worked its way into the stomach, but its point of entrance did not feel like an orifice of the stomach on account of the cicatricial contraction. The stricture was divided by means of the string-saw until full sized bougies could be passed from above. After this the opening into the stomach was treated by the method of Kader for feeding purposes, and a silk ligature was brought out through this and through the mouth, in case any recontraction occurred or any difficulty in passing bougies. He made a good recovery, and after an interval of five days bougies were easily passed from above into the stomach on two occasions. The patient died rather suddenly ten days after the operation, and the autopsy showed an area of gangrene surrounding the gastrostomy wound in the stomach.

DR. MEYER said it was rather surprising that these operations within the oesophagus by means of the string did not prove more troublesome than experience had shown them to be. This was probably due to the superficial character of the wound made by the string. The speaker said that in a case of internal oesophagotomy which he reported to the Society fifteen years ago, the operation was followed by acute meningitis and death. Dr. Meyer highly recommended Dr. Abbe's ingenious method of introducing

an instrument through the stricture, and using the string and its subsequent dilatation with the help of Dr. Dunham's instruments. After one or two sittings, the stricture is sufficiently dilated to permit the gastric fistula to heal.

CYSTOCELE COMPLICATING INGUINAL HERNIA.

DR. OTTO G. T. KILIANI presented two young men who had recently been operated on at the German Hospital, one by Dr. Kammerer and the other by Dr. Kiliani. Both had been regarded as cases of simple inguinal hernia, and, as there had been no bladder symptoms, the cystocele was an unexpected complication. The section of bladder involved was extraperitoneal, and in both instances presented itself as a typical lipoma. In both cases the bladder was recognized, and an injury avoided.

As to the frequency of this complication, Dr. Kiliani said it existed, according to one author, in 1 to 3 per cent. of all cases of inguinal hernia, while another writer had put the figures as high as 30 per cent. The latter (W. Becker, of Braun's Clinic) probably had met with it so frequently because he only operated on cases of very large hernia.

DR. JOHN B. WALKER said he had seen three cases of hernia of the bladder in adults, but in none of them was there a distinct lipoma: there was merely an increase in the fat.

TUBERCULOSIS OF THE WRIST-JOINT TREATED BY BIER'S METHOD.

DR. WILLY MEYER presented a man, forty-two years old, who came under observation a year ago. He had tuberculosis of the left wrist, all the tendon sheaths being involved. As the patient's general condition was very poor and functional result of wrist-joint resection at his age rarely good, the conservative plan of treatment by Bier's method was decided upon instead of operative interference. The patient was informed that the treatment would take many months. An elastic bandage was applied to the arm above the wrist, the object being to keep the parts in a continuous condition of venous hyperæmia. Twice daily the bandage was removed and the arm was massaged. It was then applied at another place. After the first week's treatment the pain at night, which had given the patient much annoyance, had disappeared.

The treatment was kept up faithfully, but had to be interrupted for a time on account of the development of an abscess at the wrist, which was aspirated and injected with an emulsion of iodoform. After six months the bandage was applied only at night. The treatment has resulted in an entire cure, and Dr. Meyer thought that this method of Bier should be more frequently resorted to in tuberculosis of the joints of the extremities.

DR. GEORGE R. FOWLER said it had always been a source of wonder to him that the Bier method had not found more advocates, particularly among orthopædic surgeons, who probably see many more cases of tuberculosis of the joints than do the general surgeons. Many years ago Laënnec called attention to the fact that pulmonary tuberculosis was rarely associated with certain forms of cardiac disease, and this immunity he attributed to the stasis of the blood in the lungs resulting from the cardiac lesion. The same principle is applied in Bier's method, which produces a venous hyperæmia in the region of the diseased joint. Dr. Fowler said he had employed it in tuberculosis of the wrist, elbow, knee, and ankle, and, while his results had never been as brilliant as in the case shown by Dr. Meyer, decided improvement had always taken place. The great drawback was that, on account of the long duration of the treatment, patients were very apt to grow careless or abandon it entirely. The usual treatment of these cases by means of a fixation bandage of plaster-of-Paris produced a certain amount of stasis, and the good results obtained were possibly attributable in some degree to that fact.

DR. KILIANI said that the original idea of Laënnec, to whom Dr. Fowler had referred, was that pulmonary tuberculosis did not occur in severe cases of scoliosis, where the entire pulmonary system was in a state of stasis.

Dr. Kiliani said that Bier's method of treating tubercular joints certainly gave good results, and should be used more than it is. Some years ago he showed six cases at a meeting of the German Medical Society treated by this method. In two of the cases the wrists were affected. The best results were obtained in comparatively young patients.

DR. WILLY MEYER, in closing, said he had first resorted to the Bier method in 1893. Eight years ago, at a meeting of the Orthopædic Section of the New York Academy of Medicine, he showed a case of tuberculosis of the elbow-joint in a man of fifty

that had been entirely cured by this method. He had also successfully treated a number of cases of tuberculosis of the wrists and knees by this same method. One great advantage of the treatment was that the patients did not have to remain in the hospital, but could be treated at home or at the dispensary.

THE TOXICITY OF APPENDICITIS, WITH REPORT OF A CASE OF "VOMITO NEGRO."

DR. GEORGE R. FOWLER read a paper with the above title.

DR. WOOLSEY said that the only examples of black vomit he had ever seen were in cases of fatal diffuse septic peritonitis. The matter vomited in those cases was quite watery in consistency, dark-brownish in color, and its sediment, upon examination, proved to contain blood or blood pigment. The peritonitis in the cases he had in mind did not result from appendicitis, except in a single instance.

DR. JOHN F. ERDMANN said he had never had a case of "black vomit" in which its occurrence could be ascribed to appendicitis alone, but within the last fourteen months he had seen two cases where it occurred after operations on the appendix and gall-bladder, done at the same time. In the second case, which occurred very recently, the bloody vomiting commenced immediately after the man left the operating table, and continued without cessation for two and one-half days, when death occurred. The vomiting was not expulsive in character. In the other case, which occurred about a year ago, the train of symptoms was practically the same, excepting that the vomitus became bilious in character on the second day.

DR. WILLY MEYER said he had seen a number of cases of "black vomit" following acute appendicitis, probably eight or ten in all; but he had not reported them because he had never succeeded in getting an autopsy. In all the cases the complication followed acute appendicitis, with septic peritonitis. It was his impression that this kind of vomiting was oftener met with in cases of peritoneal sepsis rather than of septic peritonitis. The coils of intestines were highly injected, dry, and sometimes the intestines were covered with a fibrinous exudate. In the majority of the cases the patients died. Lavage of the stomach did not affect the vomiting. In one case of acute gangrenous appendicitis,

without perforation, which he operated on last summer, black vomiting set in on the third day; that patient recovered with stomach lavage. Dr. Meyer said he had always had the impression that the "black vomit" was more apt to occur in cases of acute appendicitis in which operation was unduly delayed. He thought the possibility of its occurrence was another argument in favor of early operation in acute appendicitis. The speaker said Kehr, of Halberstadt, had seen many instances where the "black vomit" followed an operation for acute cholelithiasis. He agreed with Dr. Fowler and other authors that it was due to ulceration of the gastric wall in consequence of septic infection.

DR. KILIANI recalled two cases of appendicitis, both in young girls, where the operation was followed by a low, septic temperature. Black vomiting set in on the fourth and fifth day, respectively, and both cases terminated fatally. The vomitus contained blood.

DR. BLAKE said he thought that perhaps the occurrence of "black vomit" could be ascribed to general septicaemia and cellular degeneration. It was very likely that the gastric juice had a selective action upon the tissues of the stomach wall after the latter became devitalized. He did not believe that the condition was always due to a septic embolism.

DR. FOWLER, in closing, said that in the cases reported by Dr. Erdmann, where the "black vomit" set in almost immediately after operation, it might have been due to some punctate haemorrhages, attributable to forcible emesis incident to the ether, rather than to septic embolism or as the result of the effects of toxic products upon the gastric mucosa. It was certain that one might get "black vomit" without the presence of appendicitis, peritonitis, or strangulated hernia. The phenomenon had been observed in various fevers and in severe malarial infection. Still, this did not alter the fact that in the type he had described the vomiting was evidently due to the toxic effects of the bacteria or their products originating from the diseased appendix. Even mild attacks of appendicitis might be accompanied by a moderately severe thrombophlebitis of the veins of the mesentery, and the infection might be carried in this way into the portal and pulmonary circulation, or even into the lumbar veins. While the occurrence of this type of vomiting was not necessarily confined to extremely virulent cases of appendicitis, it was usually limited to such cases,

and, as they were more apt to give rise to peritonitis than the mild cases, "black vomit" was naturally seen most frequently in the presence of peritonitis. The condition of dry peritonitis, referred to by Dr. Meyer, might be present, without any exudate, and still there be sufficient infection present to produce "black vomit." The suggestion made by Dr. Meyer to operate early was very important; yet in one of the speaker's cases in which the "black vomit" occurred the operation was done within twenty-four hours after the onset of the symptoms. In appendicitis it was sometimes difficult to decide whether we were operating early or late until the abdomen was opened.

THROMBOSIS OF THE SUPERIOR AND INFERIOR MESENTERIC ARTERY.

DR. OTTO KILIANI described the following case. The patient was a man who was admitted to the medical ward of the German Hospital on February 20, 1903, with the following history:

Twelve days ago pain in right hypochondriac region and diarrhoea. On the first day, twelve movements. This diarrhoea lasted four to five days, having from ten to twelve stools every day. After this the patient became constipated and was compelled to take laxatives. The pain in the abdomen was continuous, at times quite severe; colicky pains. Abdomen tense, hard, and very tender. Never noticed any blood in stools. Heart action irregular, first sound at apex indistinct. Diazo and Widal negative. February 23 he was transferred to the surgical side with marked peritonitis. Operation showed a large part of the ileum gangrenous; one small perforation in ileum was found. No strangulation, invagination, internal hernia, volvulus, or obturation found. Mesenteries thickened and inflamed. No pulse could be felt in the larger branches of the mesenteric arteries. Diagnosis of thrombosis of the mesenteric arteries was made, and, as the lesion was too extensive to warrant any operation on the gut itself, abdomen was closed. Death a few hours after operation. Post-mortem showed the upper eight feet six inches of intestines in fairly healthy condition; the other portion, consisting of lower part of jejunum and entire ileum, down to ileo-caecal valve, gangrenous. Length of gangrenous gut, ten feet six inches. Mesentery gangrenous. Vessels collapsed distally, thrombotic at proximal ends. Thrombi found at junction of branches to superior mesenteric.

Both kidneys show pale infarct, sharply defined, of the size $1\frac{1}{2} \times 1\frac{3}{4} \times 1\frac{1}{4}$ inches in the right, $1\frac{3}{4} \times 1\frac{3}{4} \times 1$ inches in the left kidney.

Heart: valves fairly good, muscle shows interstitial changes. In left ventricle dark red blood-clot, attached to cordæ tendineæ.

Aorta: from arch to bifurcation atheromatous placques. Superior mesenteric itself patent, but its branches occluded by bright red clots. Inferior mesenteric shows bright red clot at its branching from the aorta three-sixteenths of an inch in diameter. Right common iliac normal, but that bifurcation shows well-formed clot.

Koelbing (Bruns's *Beiträge*, Vol. xxxiii, 1902) has collected forty-nine cases in literature of arterial thrombosis, and fifteen cases of thrombosis of the veins. No operated case had been diagnosed rightly. Two cases operated with favorable results, one by Elliot. Mistaken diagnosis, forty-eight inches resected. Second case, Lindner (Koelbing), resection of fifty centimetres of gut.

DR. WOOLSEY said that a year ago last summer he saw a woman between thirty and forty years of age with symptoms of septic peritonitis. There was no suspicion as to the cause of the peritonitis. Upon opening the abdomen, he found that the intestines were bluish-green in color, and there was a brownish, watery fluid in the peritoneal cavity. The condition of the appendix, liver, gall-bladder, and pancreas was investigated, and found to be normal. The patient died within twenty-four hours, and the autopsy showed an embolism of the superior mesenteric artery. Almost the entire small intestine and a part of the large were gangrenous.

Stated Meeting, March 25, 1903.

The President, LUCIUS W. HOTCHKISS, M.D., in the Chair.

RECURRENT ENDOTHELIOMA OF THE PAROTID GLAND.

DR. GEORGE WOOLSEY presented a young man who was operated on by Dr. Woolsey in May, 1900. The history he gave at that time was that two and one-half years previous to that date

(in 1897) he had been operated on in San Francisco for a tumor involving the left parotid gland, which had been pronounced an endothelioma. At the time of the primary operation the tumor was not very large, but had been growing for about two years. After the first operation, the wound had never healed entirely; a sinus persisted, which had been scraped at the New York Hospital. Various other methods of treatment had also been resorted to, and when Dr. Woolsey first saw the patient, liquid air was being tried upon the wound as a caustic.

An examination revealed a swelling which involved the whole left parotid region and extended down below the angle of the jaw. There was an open sinus below the lobe of the ear which could be traced forward towards the angle of the jaw. The tumor was very hard; it apparently involved the entire gland, but had not spread outside the capsule of the gland. Its removal was attended with the usual difficulty in such cases, and necessitated the ligation of the external carotid artery and the temporo-maxillary vein. The facial nerve, which was embedded in the tumor, was divided, and, as a result of this, the man now had a left facial paralysis. Otherwise, his recovery was uneventful. Winking in the left eye is confined to the lowering of the upper lid, probably from gravity; the lower lid cannot be raised. The patient has never had any trouble from the collection of food in the mouth, the dribbling of saliva, and but little from lachrymation and the resulting epiphora. He shows how little trouble a complete facial paralysis may cause a patient.

The tumor was sent to Dr. Ewing, and he pronounced it an endothelioma, a variety of growth which is not uncommon in this region. It was similar to the type of growth described by von Volkmann, rather than to those commonly seen here. Its structure was very much like that of carcinoma, but it was usually less malignant and rarely recurred. In this case the second operation was done almost three years ago, and there are no signs of a recurrence. The wound closed readily after the operation, and has remained so.

DR. CHARLES L. GIBSON said that over three years ago he saw a recurrent growth involving practically the whole parotid gland, which he removed *in toto*. The tumor had been subjected to a number of pathological examinations, and had been pronounced an endothelioma. There had been no recurrence since

the second operation, and it was rather strange that it should have recurred after the original one. In striking contrast with this case was one of endothelioma of the submaxillary gland, where removal was followed by a prompt and diffuse recurrence, involving the soft parts of the neck and jaw and causing death within six or eight months by metastatic involvement of the spinal cord. Endothelioma in other than glandular regions of the body usually remains localized, and does not show any tendency to malignancy.

DR. WOOLSEY said that in the case he had shown it was possible that recurrence was due to the fact that the entire tumor had not been removed at the original operation. He had some reason to suspect this because of the fact that the wound had never healed after the first operation.

PLASTIC OPERATION AFTER EXCISION OF EPITHELIOMA OF THE CHEEK.

DR. CHARLES H. PECK presented a man, forty-nine years old, who was operated on seven months ago for the removal of an extensive epithelioma involving the left cheek and angle of the mouth. The growth had existed about a year, and had invaded the tissues to such an extent that the results of the excision were not regarded as very promising.

In order to close the large gap left after removal of the growth, a flap was taken from the corresponding side of the neck and carried upward, so that it now formed a part of the left cheek and the angle of the mouth. The flap was not everted, as was usually done in these plastic operations. Its inner surface, which now forms part of the oral cavity, was allowed to heal by granulation. There had been very little shrinkage in the size of the flap, and the cosmetic effect of the operation was excellent. Thus far there were no evidences of a recurrence of the epithelioma.

The dimensions of the portion of cheek removed were, length, two and one-eighth inches; width, one and three-eighths inches; thickness (greatest), seven-eighths of an inch.

DR. HOWARD LILIENTHAL asked Dr. Peck how the development of the epithelium on the inner surface of the flap progressed? He thought it would be interesting to note, in such a case, whether the process was analogous to that described by Dr. Otis in the

healing of strictures of the urethra after urethrotomy, where the defect is covered with epithelium of normal mucous membrane, and not with cicatricial tissue. In Dr. Peck's case, the inside of the cheek has the peculiar appearance of normal mucous membrane.

DR. PECK said the color of the inner surface of the flap was rather more natural now than it was during the first few weeks following the operation. So far as he could follow the healing process, it was of the nature of the development of normal mucous membrane rather than true cicatricial tissue.

DR. F. KAMMERER said that he had never applied such a method for the correction of defects of the cheek, because he had always feared contraction during healing of the raw surface on the inside of the flap. The results after flap operations for the correction of defects of the lower lip, according to Volkmann's method, are not always very encouraging from a cosmetic point of view. He further mentioned a case in which he had removed the entire cheek for carcinoma, substituting therefor a large flap from the frontal region with its base at the zygoma. The flap was turned, bringing its external surface to the inside of the mouth and leaving the raw surface to be closed later by transplantation, according to Thiersch. After ten days the pedicle was divided, the flap retained its vitality throughout, but contracted rapidly. Unfortunately, an early recurrence interfered with the final result. No doubt the plan which had been recently suggested of immediate transplantation of epithelium upon the raw surface of the flap was the better one.

DR. HOTCHKISS said that some years ago he did a similar operation upon a patient at the Skin and Cancer Hospital, who had had an epithelioma of the lower lip removed, leaving a defect of the angle of the mouth. In that case the flap was taken from the neck, as Dr. Peck had done. The immediate result of the operation was excellent, but the patient was lost sight of soon after his discharge from the hospital, and he did not know how the case eventually turned out. Dr. Hotchkiss said that, in mapping out these flaps, allowance should always be made for a certain amount of contraction. The method employed by Dr. Peck was certainly simpler than turning in the skin surface of the flap and covering the raw outer surface with skin grafts. The formation of new mucous membrane in the case exhibited demonstrated that the simpler operation might be equally effectual.

SARCOMA OF THE SCAPULA.

DR. HOWARD LILIENTHAL presented a girl of seventeen who was admitted to Mount Sinai Hospital October 16, 1902. Her family history was negative, and her previous history contained nothing of interest. One week before her admission she had first noticed, and then by chance, a lump over the right shoulder-blade. It was painless and had caused no disability. It had not apparently increased in size since it was first observed, and, according to the patient's statement, it had not caused any impairment of her health or strength.

Upon examination, the patient was found to be fairly well nourished. No glands could be felt excepting the left inguinal, which were slightly enlarged. There was an inconstant musical murmur of the heart, heard over the third left cartilage. An examination of the other organs proved negative.

In the right scapular region was a rounded mass, confined to the lower and outer two-thirds of the infraspinous fossa, and not involving the posterior border of the scapula. The mass was about the size of a large orange, smooth and elastic, but firm. The skin covering it was movable and normal in appearance. There were no dilated blood-vessels over it. The anterior border of the scapula was free, and the growth did not encroach upon any of the adjacent tissues. The axillary glands were not enlarged.

Two days after the girl's admission, a small section of the growth was removed and submitted to Dr. F. S. Mandlebaum, the pathologist of the hospital, who reported that it was a small, round-cell sarcoma. Three days later the patient had a chill, and her temperature rose to 102° F. The mass was evidently increasing in size, and the small wound through which a section had been removed looked red and inflamed. On October 24, the temperature had dropped to 99.8° F. On the 26th, two minims of Parke, Davis & Co.'s preparation of Coley's fluid were injected into the tumor; no reaction. On the 27th, four minims were injected; no reaction. On the 28th, six minims were injected, and on the following day the temperature rose to 102.8° F.; there was an area of redness about the wound, and the skin was slightly elevated. At this time the tumor measured thirteen centimetres in each diameter. On the 30th the temperature had fallen to 99° F. and the redness about the wound had decreased. On the 31st, twenty minims of Coley's fluid were injected, and on November 1, twenty-five minims. There was no reaction, but the mass

was perceptibly smaller. The size of the injections was daily increased until the dose had reached fifty minims. Some of these injections were followed by a slight chill, while others caused little or no reaction. On December 8 one minim of Buxton's preparation was injected: this was followed by a rapid rise of temperature from 98.8° to 104.4° F., with an accompanying chill. The same dose was repeated every day for three or four days, with very slight reaction. During this entire period of treatment, the patient was also subjected to daily exposure to the X-rays, each sitting lasting from ten to fifteen minutes. On December 13, there was considerable tenderness and swelling at the site of the injection: this disappeared under the application of an ice-bag. On December 25 it was noticed that the spine of the scapula had become more easily palpable. On January 3, of the present year, Parke, Davis & Co.'s fluid was substituted for the Buxton preparation, fifty minims being injected daily. The tumor continued to decrease in size, and on January 29 the injections were discontinued.

Dr. Lilienthal said that the improvement steadily continued, and at the present time the tumor can no longer be felt. A cutaneous thickening, however, still persists, which is apparently due to the use of the X-rays. The patient steadily improved in weight, and was discharged from the hospital February 8. The speaker said that his reason for not operating in this case was that an operation would have necessitated the complete removal of the scapula. On that account he determined to give Coley's fluid and the X-rays a brief, preliminary trial. If no improvement had occurred within a very short time, he would have resorted to operation.

CORTICAL BRAIN ABSCESS.

DR. HOTCHKISS presented a man, twenty-one years old, who was admitted to the hospital on November 6, 1902. He had been struck on the head by a falling rock, which produced a simple fracture of the skull on the right side, with the subsequent development of a large haematoma. On admission, the patient was stupid and but partially conscious; the pupils were equal. The stupor gradually became more pronounced, and on November 17, Dr. Hanscom, the house surgeon, under the supervision of Dr. Le Boutellier, made a large horseshoe-shaped incision through the scalp, and found a non-depressed, comminuted fracture of the skull. The skull was trephined, and an irregular section of bone,

about three inches by two inches, which was found loose in the centre of this fracture, was removed. There were several fissures which extended to the base of the skull. There was a small extradural and a very large intradural clot, and upon washing these out, a laceration in the cortex of the brain was discovered. The wound was closed, with drainage, and, with the exception of the development of a hernia cerebri, the patient apparently made an uneventful recovery, and was discharged December 7, 1902.

He was readmitted to the hospital on February 8, 1903, complaining of severe headache, dizziness, and pain in the skull. There was a diffuse cellulitis over the right side of the scalp and forehead, involving the right eye. After evacuating some pus from the superficial abscess, a large fluctuating tumor could be made out, apparently within the skull and over the site of the original injury. The large, horseshoe flap which had been made at the time of the original operation was again laid back, and a large abscess in the cortex was opened and drained. The abscess was situated very close to the motor area, but it had given rise to no motor symptoms. This was probably due to the fact that pressure upon the brain had been relieved by the large opening that had been left in the skull. After the second operation, a hernia cerebri again developed, which had to be cut off at various times. The patient's further recovery was uneventful.

Dr. Hotchkiss said the case showed the possibility of late cortical infection, even after the external wound has apparently healed.

DR. OTTO G. T. KILIANI said that at a recent meeting of the Society he had shown a patient upon whom he had operated for tumor of the brain. An extensive cavity was left after removal of the tumor, which was temporarily tamponed with iodoform gauze, and when the gauze was taken out the bone-flap could not be accurately approximated to the gap left in the skull. On account of this displacement, a slight bony necrosis resulted and a small fistula developed. The patient continued to improve, and finally insisted on going home. Four days after his departure from the hospital he suddenly died. An autopsy showed that the cause of his death was meningitis, traceable to this small fistula, which had persisted for two and one-half months.

DR. WOOLSEY said the following case was of interest, as bearing upon the possibility of late suppuration after injuries of the skull. The patient was a butcher, who, while entering a cold-

storage place, ran his head against a meat-hook. This produced a scalp-wound of the right frontal region, which was thought nothing of; it rapidly healed, and apparently gave him no further trouble. Six years later he came to the hospital, presenting a large, red swelling of the scalp over the site of his previous injury. After opening this abscess and evacuating the pus, a probe was introduced, which imparted the sensation of an ordinary compound depressed fracture of the skull. Dr. Woolsey operated and found such a fracture, which had healed. There was an abscess between the scalp and the bone, and another underneath the skull, between the bone and the dura (epidural). The bone was somewhat eroded but not necrotic.

A CONTRIBUTION TO THE RADICAL CURE OF LARGE UMBILICAL HERNIA.

DR. FORBES HAWKES read a paper with the above title.

DR. LILIENTHAL said the specimen shown by Dr. Hawkes in connection with his paper clearly demonstrated the intimate way in which the fibrous tissue invaded the interstices of the silver netting. The speaker said he had never resorted to the use of silver filigree in the closure of these large ventral herniæ, having always been somewhat timid about the introduction of a foreign body in this region. In one instance he succeeded in closing a large gap in the median line, which could not be brought together by lateral sutures, by passing the sutures up and down, thus making the line of suture transverse, and keeping the patient in bed, with the thighs flexed for a long time after the operation. After seeing the specimen shown by Dr. Hawkes, Dr. Lilenthal said he would be less reluctant to try the implantation method.

DR. KAMMERER said it was not unusual to get primary union in these cases. The method described was advocated by the late Dr. Phelps in the treatment of inguinal herniæ. The speaker said he had seen three or four such operations where the wounds had healed promptly, but later on intestinal suppuration had set in, and he had been obliged to remove the silver wire after several years. As Dr. Hawkes had suggested, the material used in these cases might have been at fault, and such mishaps would not occur with the silver filigree. Dr. Kammerer said that the ultimate results in some cases he had observed in which the filigree operation was done were not entirely satisfactory, and he therefore thought it was suitable only when other methods were impossible.

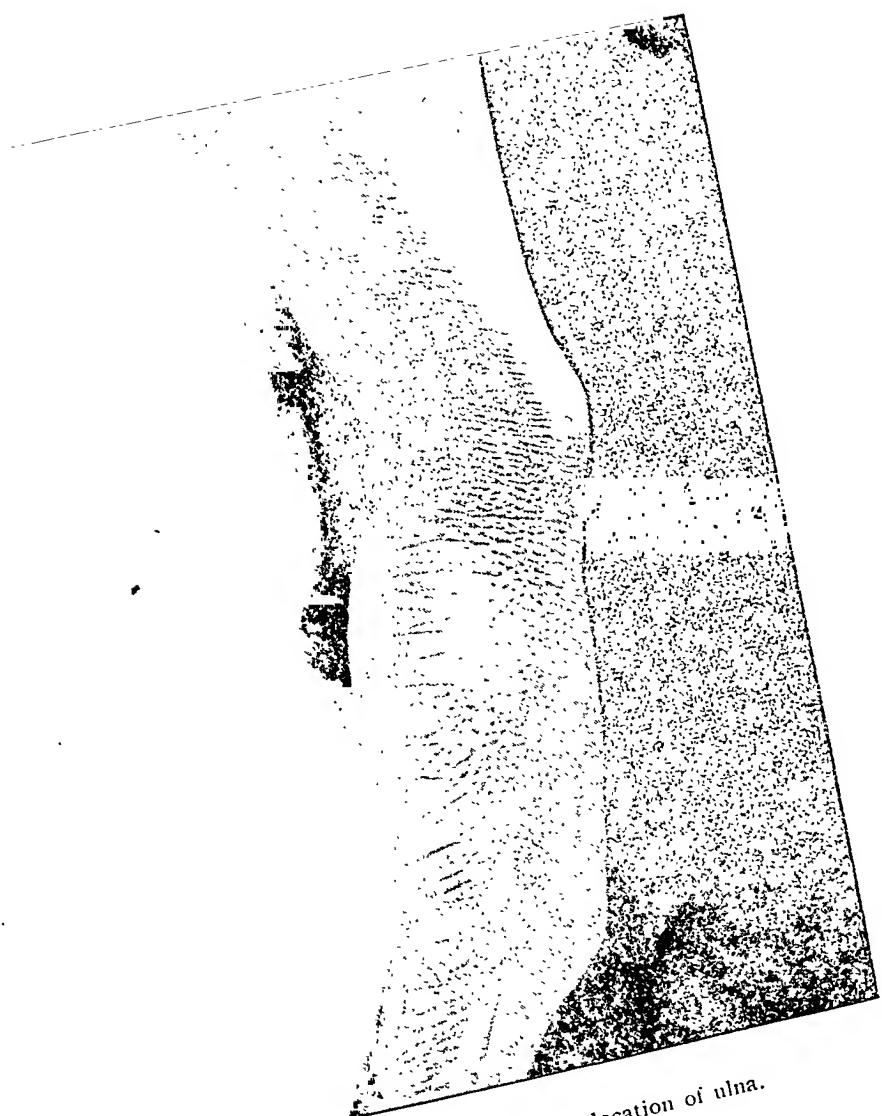


FIG. 1.—Congenital dislocation of ulna.

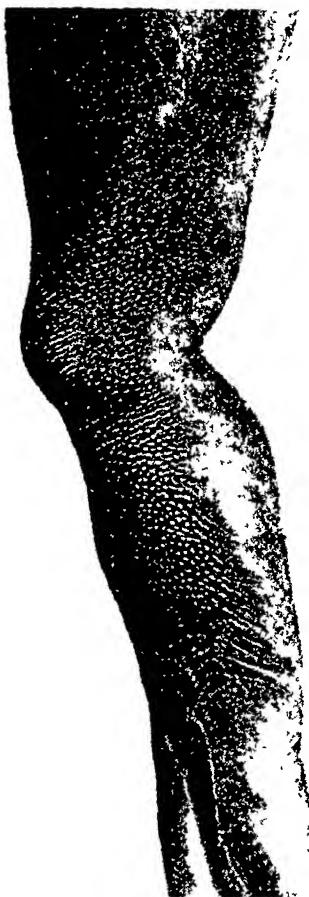


FIG. 2.—Congenital dislocation of ulna.

TRANSACTIONS OF THE PHILADELPHIA ACADEMY OF SURGERY.

Stated Meeting, April 6, 1903.

The President, RICHARD H. HARTE, M.D., in the Chair.

CONGENITAL DISLOCATION OF BOTH ULNÆ AT THE WRISTS.

DR. CHARLES F. KIEFFER reported the case of a negro man, thirty years old, by occupation a soldier, who, on presenting himself for physical examination for re-enlistment, attracted attention by the prominence of the head and styloid process of the ulna at each wrist. On examination, the left ulna was found completely displaced, overriding the dorsal surface of the carpus. The right ulna was similarly displaced, but not so completely. By strong pressure on the head of the ulna and counter-pressure on the carpus, the bone on each side could be forced a little way in the direction of its proper position. The photographs show the deformity quite well. Two radiographs also were presented,—one with the hands flat on the plate and the other with the hands on the ulnar edges, the light in both instances coming from above. The radiograph with the hands flat shows the ulna in each wrist slightly displaced outwardly. It gives no hint in either wrist of the presence or condition of the triangular fibrocartilages. The radiograph with the hands on edge is, unfortunately, not quite so clear as the first, but it shows very well how completely the ulna in both wrists is lifted above the plane of the wrist-joint.

The man says that, to the best of his knowledge, his wrists have always been as they are now. Indeed, he never suspected that there was anything unusual about them. He has been a good deal of an athlete and is a very good ball-player, showing that the deformity, as such, has produced no loss of function.

Mobility is not impaired, nor would we expect much impairment on account of the secondary part the ulna takes in the function of the wrist-joint.

This condition is very rare. What may be considered a partial development of it is sometimes encountered, where there is unusual mobility of the radio-ulnar articulation due to relaxation of the anterior and posterior radio-ulnar ligaments. In these cases the ulna slips a little bit out of place and back into place again with a click like a cracking knuckle.

A WELL-PROPORTIONED ANATOMICAL MODEL.

DR. GEORGE McCLELLAN showed a young man who, from an artistic stand-point, is one of the most perfectly formed men he has ever seen. For many years Dr. McClellan had endeavored to find a man possessing properly proportioned measurements, but from a study of hundreds of living and dead bodies this is the first that answers the requirements. There are so many fads in physical training that all sorts of disproportionate results are seen when men are closely examined. Sandow has developed wonderful strength, but from an artistic view is only a monstrosity. In the man exhibited, the muscles are covered by a normal amount of fat, and only come into relief when exercised, which gives the most perfect form. Dr. McClellan holds that the standard measurement is that when the distance from the top of the head to the soles is eight head-lengths, and this is the only man he has ever found that possesses exactly this measurement. The head-length is eight and one half inches and the body sixty-eight inches. Attention was called to several points showing remarkable symmetry in the various measurements of the body. Between the points of the shoulders is two head-lengths; between the trochanters, one and one-half; between the nipples, one; the trunk is two and one-half head-lengths long; the upper limbs, three; the lower limbs, four. The difficulty in finding a figure that is perfectly developed is not understood by most people, the trouble being that one part, particularly the upper or lower portion of the body, is often well developed, and the others are lacking. The famous statues made 400 to 500 B.C. are all, with possibly the exception of one,—the Resting Mercury,—made as composites.



FIG. 3.—Congenital dislocation of both ulnae; anteroposterior skiagram.

FIG 4.—Congenital dislocation of both ulnae, lateral sketch.



RUPTURE OF THE LIVER AND LACERATION OF THE RIGHT KIDNEY; RECOVERY AFTER OPERATION.

DR. THOMAS R. NEILSON reported the history of a man, twenty-six years of age, who was admitted to the Episcopal Hospital on June 7, 1902. On the evening of June 4, while standing on a high step-ladder for the purpose of decorating a church, he lost his balance and fell a distance of some ten feet, striking his right side from the lower ribs to the crest of the ilium upon the arm of a pew. Immediately after the injury he was taken to his home, walking with the aid of friends. The history for the time previous to his admission to the hospital was that there was pain, especially on deep breathing, in the region of the right lower ribs; there was great accumulation of gas in the stomach, and for a time general distention of the abdomen; twice a little blood was vomited; dark-colored urine was voided naturally; there was no evacuation of the bowels, although considerable flatus was expelled.

On admission to the hospital the condition was as follows: The lips and conjunctivæ were blanched; temperature, $97\frac{2}{5}$ ° F.; pulse, 120, and almost imperceptible; respiration, 24 to 26; chest negative; abdomen, tenderness in upper right quadrant, with marked rigidity of the rectus muscle in that portion; tenderness in axillary line over lower ribs; liver-dulness extends two and one-fourth inches below right costal margin. Once after admission the patient vomited a small amount of blood. About an ounce of bloody urine was voided. A catheter was passed, but no more urine could be obtained. Boric acid solution was injected into the bladder and the whole amount returned clear. The leucocyte count was 12,600.

The indications of haemorrhage were of course plain. The haematuria pointed to kidney injury, but the increased extent of liver-dulness, and the tenderness in the right upper abdominal region with rigidity of the upper part of the right rectus muscle, caused him to believe that the chief injury had been sustained by the liver, and accordingly operation was done with that in view.

Tincture of digitalis, ten drops, and strychnine sulphate, $\frac{1}{40}$ grain, were given hypodermically, and normal salt solution, one and three-fourths pints, was given by hypodermoclysis. The patient's condition was somewhat improved after this.

Through the right rectus, a five-inch incision was made, beginning at the costal border. On opening the peritoneum a considerable amount of dark fluid blood was found in the cavity. The peritoneal and fibrous coats of the liver were greatly distended. The parietal peritoneum in front of the upper pole of the right kidney was torn, and the kidney at this part was found to have been slightly lacerated. No fracture of the lower ribs was found.

An incision through the coverings of the liver was made, and a large amount of dark blood escaped. A considerable quantity of clots was removed by the hand, which on being passed to the posterior border of the right lobe of the liver discovered a rupture of the organ at that position. The region was flushed with hot sterile water, and the bleeding appeared to be arrested.

The patient was then turned partly on the left side, and an incision made between the eleventh and twelfth ribs of the right side just about the posterior axillary line. A long piece of iodoform gauze was then placed in a large rubber drainage tube, the latter being split lengthwise and passed into the abdominal wound, then into the wound made in the serous and fibrous coverings of the liver and brought out through the wound made between the ribs. Another piece of iodoform gauze was packed below the liver and over the upper end of the right kidney and brought out through the posterior wound. The abdominal wound was closed, except around the through-and-through gauze pack, with interrupted silkworm-gut sutures.

The patient did well after the operation, and made steady progress towards recovery. The small gauze pack was removed and replaced one week after operation, and the large one was taken out on the tenth day, being replaced by small iodoform gauze drains inserted into both the abdominal and the posterior wounds, and these were gradually dispensed with. Healing of the wounds progressed favorably.

On July 24 the patient was able to get out of bed, and on the 28th, fifty-one days after operation and fifty-four days after the injury, he was discharged recovered.

DR. DE FOREST WILLARD said that about two years ago he had operated on a case of ruptured gall-bladder. The patient was a child who had been crushed by a wagon wheel, but, as it was not seen until two months after the injury, it was uncertain whether the liver had also been ruptured. The extravasated blood

and bile had been walled off from the peritoneal cavity, and from this cavity he had removed sixty-four ounces of almost pure bile. (*New York Medical Journal*, lxxv, 369.)

DR. G. G. DAVIS related the case of a man who received a blow in the right side, which was followed by acute symptoms consisting of intense pain and abdominal rigidity. There was also dulness in the flanks. Rupture of the liver was suspected and median incision above the umbilicus was made. Blood gushed forth when the peritoneum was opened, and search revealed that it came from between the liver and diaphragm. This space was tightly packed, but the man died soon after from shock. Autopsy showed a rent four inches long in the upper surface of the liver near its ligamentous attachment.

DR. JOHN H. GIBBON referred to a case which came under his care at the Bryn Mawr Hospital, which in many ways resembled Dr. Neilson's case, and which at first was thought to be one of rupture of the liver, but which on operation proved to be a rupture of the spleen. The patient was a boy who fell from a tree on Friday afternoon. In a short time he recovered from the immediate shock of the fall and said nothing about the injury when he arrived at home. The following morning, however, he was found very much shocked. He was admitted to the hospital on Saturday, but it was thought at this time he was too ill to be operated upon. Dr. Gibbon saw the patient first on Sunday afternoon. The patient presented every symptom of severe intra-abdominal haemorrhage. His pallor was marked, his pulse was rapid and weak, and his respirations very much increased. Examination of the abdomen revealed no particular point of pain, tenderness, or rigidity. The abdomen was somewhat distended, with a dull percussion note in both flanks when the patient was recumbent. When the child was turned over on his side, the upper flank became resonant and the dulness of the other greatly increased. There was no evidence of confined blood in either kidney region, nor was there any tenderness here. The patient's urine showed considerable macroscopic blood on the day of admission, but this had become much less when he was seen on Sunday. There seemed little doubt that the kidney was involved in the injury, but at the same time it was clear that the abdomen contained a large amount of free blood. Although the child's condition was very bad, it was deemed wise to open the abdomen

and attempt to arrest the bleeding. In the absence of any particular indication, it was thought that the liver was the most likely organ to be lacerated, and therefore an incision was made on the right side of the abdomen below the costal border. A quantity of free blood escaped when the peritoneum was opened, but the liver and other organs on the right side were uninjured. The blood appeared to come from the opposite side of the abdomen, and therefore a second opening was made below the left costal border. The descending mesocolon and the peritoneum over the kidney were markedly injected with blood. When exploration was carried upward, clots were discovered, and later a laceration of the spleen, which admitted three fingers. The wound was firmly packed with gauze, the abdominal cavity irrigated with hot salt solution, and the wound on the right side closed. When these procedures were completed, it was found that the packing had thoroughly controlled the bleeding, and therefore it was left in position and the wound partially closed. The patient made an uneventful recovery, excepting for a slight left-sided pleurisy with some effusion, from which, however, he rapidly recovered.

REMOVAL OF A LARGE LOOSE PIECE OF BONE FROM THE KNEE-JOINT ONE YEAR AFTER BEING RUN OVER BY A FREIGHT-CAR; FUNCTIONAL RECOVERY.

DR. H. AUGUSTUS WILSON said that he was indebted to Dr. John M. Bertolet, of Reading, for the opportunity of operating upon the case, notes of which he now gave. Dr. Bertolet's radiograph (see Fig.) clearly shows the position of the piece of bone. It is a matter of interest to record the difficulty that was experienced in interpreting this radiograph by the many surgeons who saw it. The majority expressed the opinion that it was a piece torn from the tuberosity of the tibia, the error of which was demonstrated at the time of its removal.

The patient, a man aged twenty-six years, on March 17, 1903, while on a very slowly moving freight train, attempted to step from one buffer platform to the other, in doing which he slipped. In falling, he tried to escape the wheel, but did not succeed, for it passed obliquely over his right knee. The engineer saw him fall, and instantly stopped the engine in time to prevent the second wheel also passing over him, but the right hip was severely contused by the second wheel striking against it. The

Fragment of bone in cavity of knee-joint.



trousers were badly torn at his knee, but the skin was not broken. The greatest pain was experienced at the hip. He voided bloody urine for several days, and suffered very great pain in the right hip and knee as well as in the back and left thoracic region. He was at this time in a hospital in the interior of the State, where the treatment—the exact nature of which could not be ascertained, but from the patient's account appears to have been directed principally to the right knee. He remained in the hospital for five weeks, and used crutches for three weeks after dismissal. He was again admitted, and was kept in bed for four weeks because of the severe pain in the back, knee, and hip. Until September, 1902, when he discontinued the use of crutches, he was confined to bed at irregular intervals for periods of a week or two. Not until he attempted to walk without crutches was it noticed that he was unable to fully extend or fully flex his hip and knee, and there seemed to be marked shortening, which was in a large measure due to the lack of ability to extend the leg. He was admitted to the Jefferson Medical College Hospital and operated on on March 9, 1903.

A longitudinal incision five inches in length was made from the lower edge of the patella to about the middle of the tuberosity of the tibia, and immediately upon entering the joint a hard, movable mass was encountered. Efforts at removal very quickly showed that, while apparently movable, it was firmly attached by fibrous bands to the tibia, from which it was dissected. The condyles of the femur were scrutinized, but gave no evidence of having lost any of their contour. The articulating surface of the tibia appeared normal in its anterior and outer aspect, but there seemed to be an irregularity in the posterior inner portion that led to a surmise that the piece of bone had had its origin from there. Subsequent repair had largely obliterated any cavity that may have been made at the time of the accident. The bone when removed was found to have two surfaces that were covered with cartilage and were smoothly polished as though they had been in contact with the patella and condyles of the femur. The firm attachment of the bone to the tibia and its vascularity would seem to indicate that it had formerly been much smaller, but had gradually grown to its present size, which was found to be two inches long, seven-eighths of an inch thick, and one and one-eighth of an inch wide. The wound was closed without

drainage. The stitches were removed on the sixth day. There was no temperature. Mild passive motion was instituted on the eighth day and increased daily in extent and duration. On the twelfth day he was permitted to use crutches, avoiding weight bearing upon the affected leg. On the fourteenth day he walked without crutches, with very nearly full normal flexion of the knee, but with incomplete extension. There has been no severe pain in the joint nor swelling since the operation, and on the fourteenth day he was discharged from the hospital. He was again seen two weeks later, when the function of the joint was almost complete, lacking only the ability to fully extend the knee-joint.

The very unusual amount of traumatism to which the joint was necessarily subjected in the operation of removal of the piece of bone gave rise to fear that ankylosis would follow. It was for this reason that passive motion followed by active manipulation was instituted early, and weight-bearing encouraged at an earlier period than usual in operations upon the knee-joint. It is evident that the knee-joint is sometimes capable of resisting very severe injury, and the recovery in this case from the traumatism of the accident and from the extensive operation shows that with careful technique the joint may be freely invaded without loss of function. Many writers urge that only smooth steel instruments be inserted into the joints and never the fingers, whether gloved or not, but experience in this and other cases shows that such prohibition is unnecessary. Owing to a radiographic dermatitis over the right hip, it has been found impossible to obtain a satisfactory skiagraph of the hip. The study of a very faint negative by Dr. S. A. S. Metheney at the Jefferson Medical College Hospital, and the conditions around the hip, would appear to indicate an impacted fracture of the neck of the femur with complete consolidation, but leaving a slight limitation to the function. He was able four weeks after the operation to walk and go up and down stairs with only a slight perceptible limp, without pain, and with only the fatigue that would be expected in a leg that had had so little use for a year.

DR. HENRY R. WHARTON recalled a case previously reported by him in which, following a compound fracture of both bones of the leg and injury of the knee, the knee could not be completely extended. A skiagraph showed that there was a loose

mass in the joint. Several weeks later this mass was removed, and proved to be the inner condyle of the femur, which had been torn off and reversed so that the articular surface was directed upward. Good recovery followed its removal, no inversion or eversion being caused by its absence, and the man being able to walk without crutch or cane.

THREE CASES OF RECOVERY FOLLOWING OPERATION FOR PERFORATION IN TYPHOID FEVER.

DR. RICHARD H. HARTE read a paper with the above title, for which see page 63.

DR. G. G. DAVIS said that Dr. Harte need not feel chagrined over a mortality of 76 per cent. in his operations for typhoid perforation, as the mortality in these cases hinges on the character of the case rather than on the character of the operation. The importance lies not so much in operative technique as in diagnosis. The present high mortality will be lowered only when the physician and surgeon respectively are not afraid to suggest operation and to operate. Dr. Davis had operated on three cases during the past year and all died. All had general peritonitis, but the condition of each after operation was as good as it was before, hence he does not believe that operation *per se* markedly diminishes the chances of recovery. He thought formerly that inflammation of the appendix was not frequent in typhoid fever, but the number of cases he had lately seen show this to be not a rare complication. Some cases showing pain and tenderness over the appendix recovered without operation. In one case operated by Dr. Davis he found two perforations, one in the ileum and one in the appendix. The latter organ, although perforated, did not show marked inflammatory involvement, such as is found in cases of true appendicitis when the appendix alone is diseased.

DR. D. J. MILTON MILLER, who made an early diagnosis of perforation in one of Dr. Harte's successful cases, said there was at times no more difficult condition to decide upon than that of perforation in typhoid fever. There are a few signs, however, which, in a certain number of cases, enable one to make the diagnosis early. This is especially true in cases that previous to perforation have had no marked abdominal symptoms. When

the latter conditions have been present through the course of the disease, a diagnosis is very difficult to make, and is often first made in the post-mortem room. Typhoid fever patients should be watched very closely, no symptom being too trivial to be noted. The most important symptoms pointing to perforation are pain, rigidity, and increased pulse-rate. The temperature does not help us much. A rise is just as likely to occur as a fall, and distinct falls are unusual, except late in the attack, when general peritonitis or collapse is present. He had often noticed a fall of two or three degrees, but in looking back over the chart very often many similar variations could be found. The leucocyte count is unreliable. Leucocytosis is not so very uncommon in typhoid fever when there is no explanation for its occurrence. By this is meant a count of 8000 to 10,000. In one case under Dr. Miller's observation the leucocyte count was 10,000 when the patient entered the hospital. It afterwards fell slightly, and was only 9400 at the time of operation for perforation, six days after admission. Of all the symptoms pain is the most important, and the patient is usually able to fix definitely the time of its beginning. Pain during the course of typhoid fever is usually rare, and its onset of the greatest significance. Tenderness in perforation is usually localized in the lower right quadrant of the abdomen. Rigidity is usually present and comes on early. Some increase of the pulse is present in all cases. Dr. Miller does not believe in the so-called preperforative stage. The symptoms ascribed to that stage are really those of the early stage of perforation.

DR. J. P. HUTCHINSON said he believed that if the records of general hospitals were examined it would be found that the majority of cases of perforation saved by operation were among those patients that came into the receiving ward and were operated on at once. Three of his successful cases were from the receiving ward, and in all there was an element of doubt as to the exact condition present. There was no difference in their condition externally from cases of perforation in hospital wards. These statements regarding receiving ward cases are based on the fact that there are different rules for visiting surgeons and visiting physicians, the latter having fairly definite visiting hours at the hospitals, the former being accustomed to go whenever they are sent for. Hence, with medical ward cases there is apt

to be some lapse of time after a change in symptoms, unless they are very pronounced, before the patient is seen by the chief. With receiving ward cases the resident surgeon perhaps makes a diagnosis, or at least sends at once for the surgeon. Most of these cases should be operated upon even if there is an element of doubt. Dr. Hutchinson has opened two cases which were doubtful and found no perforation. One was supposed to be appendicitis, but proved to be typhoid fever. In that one there was marked improvement for two days after the operation. Operation *per se* does no marked harm. In closing perforations, the longitudinal method of suturing is the better. In every case where the speaker has tried to reinforce the sutures, there has been escape of faeces.

DR. W. L. RODMAN said he coincided with Dr. Harte's statement that the incision should be made on the right side, although in his own case the median incision fortunately was made directly over the perforation. As little time as possible should be spent in the operation. The continuous suture for closing the perforation is less effective than the Lembert with packing around the area to protect in case of giving away. In doubtful cases gauze may be sutured over the wound with catgut as practised by Mayo. The diagnosis is not always easy. He operated one case which two medical men pronounced perforation, but which he thought was a case of haemorrhage. The latter diagnosis was found to be the correct one. The patient recovered from the operation and died later from a second haemorrhage. This case was operated upon under local anaesthesia produced by carbolic acid. No pain was experienced by the patient except when the parietal peritoneum was handled. A second case in which carbolic acid anaesthesia was used was one of strangulated hernia. No pain whatever was caused by manipulation of the intestines, but there was some, as in the first case, when the parietal peritoneum was handled. Flushing of the abdominal cavity in perforative cases is better than wiping. It saves time and more thoroughly gets rid of sepsis. The solution should be as hot as can be borne. Dr. Rodman is interested in the question of a preperforative stage. He thinks there is such a stage, but it cannot be recognized with sufficient certainty to warrant laparotomy in all instances. When so much difficulty is experienced in diagnosing perforation itself, how is the preperforative stage to be recog-

nized? In his own case he believes there was such a stage, showing itself twenty-four hours before the perforation. There is much in this suggestion of Cushing, and, if possible, the surgeon can at least get ready for operation; if there is a probability of perforation, he can operate at once under cocaine anaesthesia. He was glad to hear Dr. Harte emphasize the danger of waiting for reaction in these cases. The same rule as for gunshot wounds of the intestines should hold,—operate during shock in both instances. Perforations of the intestine and of the appendix have a different pathology, the small intestine being movable and the large more or less fixed. This same reason makes gunshot wounds of the small intestine more serious than those of the large bowel. Hence there is lessened gravity in appendiceal perforation, even during typhoid fever; there being less shock and sepsis than in typhoid perforation, when the lesion is usually in the small intestine.

DR. J. ALISON SCOTT believes that statistics of the time of perforation will show that in the majority of cases it occurs earlier in the course of the disease than the surgeon anticipates. He finds that many cases occur as early as the fourteenth or fifteenth day. He would explain the good results from receiving ward cases mentioned by Dr. Hutchinson by the fact that these are mild and practically walking cases. Such are in comparatively good condition and have a higher peritoneal resistance. They will get well. In cases with marked distention and pain throughout (and he finds that pain is a common symptom in typhoid), the toxæmia is great and the diagnosis of perforation is difficult. In these patients it is often impossible to make the diagnosis early. In 165 cases of typhoid under his care this winter there were three cases of perforation. All were operated upon and all died. Three things are of prime importance in diagnosis,—pain, rigidity, and tenderness. In six of eight cases of perforation coming under his knowledge pain was very sudden in onset. As a rule, it is paroxysmal. In three cases there was a chill. The temperature is of decided importance. In four of the eight cases studied it rose, fell gradually, and then rose again, the pulse meanwhile going up. Rigidity alone is not of so much importance, as it may be present in cases of pleurisy and pneumonia. The leucocyte count is not of great importance. It is usually from 4000 to 5000 in cases of typhoid, but it may jump

to 6000 or 8000 at times. A differential count, if the physician has time for it, may be of value in some instances. In the Johns Hopkins Hospital haemorrhage with perforation has been frequently noted. Dr. Scott has not seen this combination, as in none of the cases of haemorrhage seen by him has there been perforation; other observers have recently, however, seen the combination of the two.

DR. R. P. McREYNOLDS gave brief notes of four cases of perforation that he had operated upon. The first was operated upon four days after the perforation; a localized abscess had formed upon the right side; this was opened and drained. The man made a complete recovery.

The second case was operated upon about eight hours after perforation; a large opening in the bowel (the size of a twenty-five-cent piece) was found and closed. The man died some hours later.

The third case was operated upon for appendicitis, but at autopsy it was found that the cause of the general peritonitis had been a perforated typhoid ulcer.

The fourth case was operated upon about twelve hours after perforation. The diagnosis was obscured on account of severe intestinal haemorrhages preceding the perforation. The gradual increase in the leucocytes was considered of considerable diagnostic value. The boy died about seven hours after the operation.

In these cases the incision was made in right semilunar line; chloroform used for anaesthesia. In three of them cocaine was also injected along the line of incision in order to diminish the quantity of chloroform necessary for anaesthesia.

The first case shows the possibility of a localized abscess forming after a perforation from typhoid fever ulcer, just as it does from perforation of the appendix.

DR. JOSEPH M. SPELLISSY briefly detailed a case which he believed illustrated diagnosis in the preperforative stage. In that case there was a sudden rise of temperature, abdominal rigidity, tenderness, and pain. The leucocyte count was negative. Dr. Spellissy saw the patient two hours after the initial symptoms at the request of Dr. T. L. Coley, and agreed with the latter's diagnosis of possible perforation, and operated. Beside the symptoms detailed, there was present some bronchitis, and a

slight dulness over the left apex. Operation under ether anaesthesia revealed a patch on the intestine covered by lymph; the lymph was wiped off, but no perforation was present; although from the appearance of the ulcer it seemed imminent. The affected area was buried by means of Lembert's sutures. There was a free amount of peritoneal fluid, but it was clear. The case terminated fatally in twenty-four hours from pneumonia.

DR. JOHN B. ROBERTS said that increase in respiration was an important point. A sudden increase of respirations to 30 or 36, accompanied by pain in the abdomen, probably means perforation.

DR. HARTE, in closing, said that as regards cocaine he had never used it, but believed there was no doubt of its value in the hands of some surgeons. The time of recognition of the condition and the time of operation cannot be too close together, and but little time can be spent in making the toilet, which should be simple but thorough. One must get the patient off the table and into bed if any reasonable percentage of cases are to be saved. No one definite rule as to the manner of stitching the intestine can be followed, as this should be determined by the character of the perforation. It is less apt to tear when closed longitudinally. The leucocyte count is of no value, being only misleading in cases of perforation. Localized abscess is possible only when the lesion is associated with the appendix, as in typhoid fever the peritoneum does not have an opportunity to form well-marked collections of pus, as are noticed in other peritoneal conditions. After operation for perforation, the patient should be nourished by the bowel for a long time. As to the preperforative stage, there are no symptoms in typhoid perforation until perforation itself occurs; then the whole train of symptoms rapidly follow.

INTESTINAL PERFORATION PRODUCING PERITONITIS AND
OBSTRUCTION THREE WEEKS AFTER OPERATION
FOR STRANGULATED HERNIA; RESECTION
OF BOWEL; RECOVERY.

DR. JOHN H. GIBBON reported the history of a woman, aged thirty-five years, who was admitted to the Jefferson Hospital on the night of April 1, 1901, suffering from a strangulated left femoral hernia. The symptoms of strangulation were well

marked, there being faecal vomiting, moist skin, and a weak and rapid pulse. The hernia was large, extending for a considerable distance upward over Poupart's ligament. A curved incision was made along the upper border of the tumor with its concavity downward. The sac was opened and found to contain considerable dark-colored fluid, together with about five or six inches of very dark small intestine. The constriction was divided and healthy bowel drawn down into the wound. Hot water was then used freely for the purpose of re-establishing the circulation in the herniated bowel, and was followed by considerable improvement; but there was one portion which, although it had not lost its lustre, yet its wall was extremely thin, and at one point presented very much the sensation of an ulcer threatening perforation. This, of course, was due to pressure at the point of constriction. After considerable deliberation and the free use of hot salt solution, it was determined to restore the bowel to the abdominal cavity. The sac of the hernia was ligated and removed, and a portion of the pectineus muscle with its fascia was brought up and sutured to Poupart's ligament. The wound was closed with a subcutaneous suture of catgut and a subcuticular one of silkworm gut. The patient made an uneventful operative recovery. The postoperative condition was watched with a great deal of interest for ten days, but after that time it was thought there was little danger of any subsequent trouble from the injured bowel. On the eighteenth day, however, the patient experienced considerable pain and discomfort in the abdomen, but this was promptly relieved by an enema. She was then comfortable until the twenty-second day, when she again had the same pain and discomfort. The enema was repeated, but the result was not as satisfactory as on the former occasion. To the symptoms of pain and discomfort were soon added those of vomiting, slight distention, more marked on the left than on the right side, and a pulse ranging between 120 and 130. At this time there was entire absence of fever. The abdomen was then opened. As the pain was located on both sides, a median incision was made a little below the umbilicus. On incising the peritoneum, there escaped a thick, light-colored fluid, and when the hand was introduced it discovered a mass of adherent intestine on the right side. This was delivered, and more fluid escaped from the abdominal cavity. The adherent bowel was then separated and about one ounce of

thick pus escaped. The portion of bowel which had been herniated was bent upon itself, and the mesentery belonging to another portion was adherent to it, and between these two structures the pus was located. When they were further separated, a perforation of considerable size was found at the site of the former constriction. As a large portion of the bowel was deprived of its peritoneal coat in the process of separating the adhesions, it was determined that resection of the diseased portion of the bowel and end-to-end anastomosis would be the best treatment. This was accomplished without difficulty with the aid of the O'Hara forceps. Three rows of sutures were employed,—the first of silk and the last two of catgut. The portion of bowel removed measured about eight inches. A large portion of the intestine was covered by flakes of lymph, and the pelvic cavity was found to contain considerable fluid of a dirty color. The entire small intestine was drawn out of the abdominal cavity and all of the deposits of lymph were carefully wiped away with gauze sponges, and the abdominal and pelvic cavities thoroughly and for a long time irrigated with warm, normal salt solution. The intestine was then returned to the abdomen and the wound closed, except for a small space in its centre, through which a gauze drain was passed down to the seat of anastomosis. The patient was considerably shocked by the operation, and not only required hypodermic and rectal stimulation, but also the use of the intravenous injection of salt solution. During the night following the operation the patient vomited at frequent intervals. The rectal tube was introduced repeatedly and considerable faecal matter and flatus passed through it. The next day the patient was much better, and from this time on made a rapid recovery. She was heard from within the past few months, when she had had no recurrence of the hernia and no symptoms of obstruction.

Dr. Gibbon recalled the fact that Dr. T. S. K. Morton reported before this Academy in May, 1901 (*ANNALS OF SURGERY*, Vol. xxxiv, 1901, p. 318), the case of a woman upon whom he operated for a strangulated femoral hernia, who developed marked symptoms of obstruction of the bowel several weeks later. The abdomen was opened and the bowel resected, the patient making a good recovery. The obstruction in this case was entirely due to adhesion of the bowel.

In the *Lancet* of April 27, 1901, Barker reports a case in

which he resected thirty-seven inches of small intestine four months subsequent to an operation for strangulated hernia. In this case, at the time of operation, the strangulated bowel was not gangrenous, although considerably congested. Subsequently the patient suffered from two attacks of severe obstruction. At the time of the second operation there was found extensive adhesion of the intestine, with nearly complete obstruction of its caliber due to a kink. The patient made a good recovery.

Both of these cases differ from the case reported by Dr. Gibbon in the important respect that there were no abscess, no perforation, and no peritonitis present in either; but nevertheless they all illustrate the occasional necessity for opening an abdomen for obstruction a number of weeks after operation for strangulated hernia.

He added that while it was not his purpose to discuss the immediate treatment of the bowel in strangulated hernia, he desired to say, however, that it was his own practice, when the circumstances permitted of it, always to operate at once upon cases of strangulated hernia and never to employ taxis. He was also of opinion that when there is great doubt as to the vitality of the bowel, the surgeon will display better judgment by doing an immediate resection than by restoring the bowel, temporarily fixing it in the wound, or performing an artificial anus. Of course, cases which are moribund are not included in this statement.

The point which each of the three cases already quoted emphasized was that, when symptoms of obstruction or peritonitis develop after an operation for strangulated hernia, immediate opening of the abdomen is demanded. Delay at such a time is disastrous, and early operation gives wonderfully good results, even under the most discouraging circumstances.

DR. FRANCIS T. STEWART briefly reported two cases of intestinal resection. One followed a previous operation, by another surgeon, for strangulated inguinal hernia in which resection had been performed. The obstruction necessitating the second resection in this case was caused by a diaphragm made by the O'Hara forceps, which was used in the first operation. This patient died. The second patient is now convalescing from a resection made necessary by the results of an ovariotomy performed some months before. Obstruction was due to a kink in the bowel. A perforation was found at the site of kinking. This

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was sutured and the abdomen closed. In three weeks symptoms of obstruction again developed due to the formation of a stricture at the point of suturing. The stricture was resected without mechanical aid.

DR. GIBBON, in closing, said that the first case referred to by Dr. Stewart was one that he had operated upon, the obstruction being due to a diaphragm following the use of the O'Hara forceps. He has entirely given up the use of these forceps and unites the intestines without mechanical aid.

INDEX TO SURGICAL PROGRESS.

HEAD.

I. Empyema of the Sphenoid and Intracranial Complications. By DR. KANDER (Carlsruhe). To account for the obscure cases of meningitis, sufficient cognizance is not taken of the accessory cavities of the nose, and particularly does this obtain with the sphenoidal sinus and its relation to the cavernous sinus.

While the number of reported cases of empyema of the sphenoidal sinus is very small, yet this is not in accord with post-mortem findings. Thus, Wertheim found in 360 cadavers empyema of the sphenoidal sinus thirty-five times. The etiological factors in every instance were one of the acute or chronic infectious diseases; in the first place, particularly pneumonia, scarlet fever, and diphtheria. Tuberculosis markedly predisposes to sinus disease. It was not to be ascertained whether the infection spread from an acute rhinitis or whether it started anew in the sinus itself.

Three personal experiences are recounted, the first in a female afflicted with pneumonia. On the tenth day, in addition to severe cerebral symptoms, there were pain and rigidity in the neck, œdema of the lids and half of the face; diminished vision. The papilla of the optic nerve was hazy and the veins distended, and when finally exophthalmos set in, the diagnosis of thrombosis of the cavernous sinus was only too evident. The pneumonic infiltration persisted to the end. Operation was refused. The rhinoscopic examination had shown nothing, but the post-mortem revealed a bilateral empyema of the sphenoidal sinuses, thrombophlebitis of the lateral sinus, and purulent meningitis.

The second patient, a male, with a decided family history of tuberculosis and personally afflicted with "catarrh of the apex,"

had a severe coryza for four weeks, associated with a free discharge of pus from the right half of the nose. Suddenly rigidity of the neck set in with high fever, congestion of the right eyelids and bulb, with profuse lachrymation. A marked protrusion of the bulb was perceptible. Rhinoscopy showed deviation of the septum to the right; hypertrophy and tumefaction of the middle turbinated with free pus in the middle meatus of the right side. Patient otherwise markedly septic and great tenderness upon percussion of the frontal bone. This latter sign determined the diagnosis as frontal sinusitis. An operation for the relief of this failed to find the cause, and the patient's condition did not warrant search for the pus in the sphenoidal sinus, which was then suspected. Post-mortem examination brought to light a basilar meningitis; a collection of pus in the sella turcica; the right sinus cavernosa thrombosed, a perforation of the sphenoidal sinus itself containing pus.

In the third instance a bullet lodged in the sphenoidal sinus had caused suppurative signs.

The thrombophlebitis is brought about either by contiguity of inflammation of the bone to the cavernous sinus or infection is carried by the emissary veins, or finally by the lymph channels. Abscesses were always extradural.

The diagnosis is determined by the severe frontal headaches and rhinoscopic findings, and, when the cavernous sinus is thrombosed, by the additional disturbance in the ocular circulation. Where the conditions warrant it, the middle turbinated bone may be resected to aid in establishing the diagnosis.

Operation.—A resection and dilatation of the ostium may establish sufficient drainage, and if not, the frontal sinus is opened and through it the sphenoidal sinus can be reached. The posterior wall of the frontal sinus is removed and the endeavor made to locate extradural collections of pus.—*Beiträge zur klinischen Chirurgie*, Band xxxvi., Heft 1.

MARTIN W. WARE (New York).

ABDOMEN.

I. The Question of Drainage after Abdominal Operations. By PROFESSOR R. OLSHAUSEN. Olshausen gives his reasons for practically abandoning drainage after abdominal operations, and compares his results with those of operators who disagree with him. In the last twenty years the author has only used tampons for haemostasis or drainage five times. Operators, as a rule, use the tampon to prevent general peritonitis after the removal of infectious foci under the following circumstances:

- (1) If during operation pus has escaped into the belly cavity.
- (2) If remnants of tumors or abscess membrane are left *in situ*.
- (3) In cases of penetrating injuries to the gut or bladder.
- (4) If material has escaped into the belly cavity of a nature to form a good culture medium.

During the past six years the author has performed 1555 laparotomies, of which 114 ($7\frac{1}{2}$ per cent.) were severe, and in none did he drain.

The death-rate was higher than it ought to have been because of accidents (embolism, perforation of stomach), and yet was no greater than that of surgeons, e.g., Schauta, who drain.

The only real danger is in cases of recent peritonitis with multiple suppurative lesions, and in those of intestinal injuries. The history after operations in pus cases (generally pyosalpinx) was often one without fever or reaction. The gonococci in tubal pus are relatively harmless and lose their virulence when the disease has lasted nine to twelve months. Microbes which wander from the intestines, in cases of ovarian abscess and suppurating tumors, are more malignant. The most malignant organisms are the streptococci seen in peritonitis and recent injuries.

The author thinks we may discard the four indications for drainage already given. Drainage does not lower the primary mortality, because it neither protects against infection nor does

it remove it. The infection is usually generalized before drainage is begun.

On the other hand, drainage involves danger from secondary infection. Apart from thorough sepsis and recognition of indications, the principal means of safety is the dry technique and elevation of the pelvis. The peritoneum and neighboring organs must be carefully protected. Foci of pus must be carefully removed intact. If such are opened, the pus must be completely removed with gauze pads. The peritoneum, and especially Douglas's pouch, must be carefully cleaned and left dry. Perforations of gut or bladder must at once be closed by a double line of sutures, and, if possible, covered by neighboring serosa. If the bladder is sutured, permanent catheterization must be kept up for a week. Douching the peritoneum is dangerous and useless. The author completely closes the belly after all his operations, with the following exceptions: He packs cases where there is uncontrollable haemorrhage from surfaces and drains perityphilitic abscesses, because in these cases there is liable to be a renewed secretion of very virulent matter. In doubtful cases of deep-seated pelvic suppuration in women, vaginal drainage is more reasonable than suprapubic. Zweifel records 140 cases of pyosalpinx operated on without drainage, and with only one death.—*Zeitschrift für Geburtshilfe und Gynäkologie*, lxviii, Heft 2.

II. Operative Treatment of Acute Infectious Cholecystitis. By DR. KÖRTE (Berlin). Körte has operated 135 times for suppurative inflammation of the gall-bladder and ducts. In seventeen of these the operation was demanded during the attack of acute infectious cholecystitis, when stones were found in sixteen. In seven cases the gall-stones were latent, in five the troubles they occasioned were diagnosed wrong (gastronephritic colic or perityphlitis), in four the gall-stone colic was correctly diagnosed. The acute infectious cholecystitis began suddenly with chill and fever. Körte believes that closure of the cystic duct

formed a closed infected cavity, led to increased virulence of the bacteria and to increased tension, and thus to necrosis and peritonitis. Twice the acute cholecystitis supervened on a strangulation of gut in a hernia. Peritoneal infection manifested itself twice by the presence of turbid serous fluid, once by pus. The symptoms of peritonitis dominated the cases. Removal of the gall-bladder and flushing of the peritoneum led to recovery. In threatened perforation from necrosis of a portion of gut, Körte obtained protection by the use of omentum.

Like Riedel, the author found in these acute cases that the gall-bladder was inflamed, thickened, and its serosa overlaid with exudate. Abscesses might exist in the wall or between the bladder and liver. The mucosa was always softened, ulcerated by stone pressure. Spontaneous cure is possible, but improbable. The dangers from sepsis, suppuration of liver, and peritonitis are so great that operation is obligatory; the more so as even in the acute stage, on the second to the ninth day of the disease, general infection of the peritoneum may be prevented. Of seventeen patients three died, and these from complications, viz., two from myocarditis and nephritis and one from diabetes. In no case was there infection of the peritoneum (general (?)).

Körte has become a warm advocate of operation in the acute stage, and has himself performed cystotomy with drainage six times, resection with drainage and tamponade five times, and cystectomy with hepaticus drainage six times. The last operation is highly commended because it removes the focus of disease, discloses abscesses of the liver, and prevents stones being left behind.—*Versammlung deutscher Naturforscher und Aerzte, Sektion für Chirurgie*, 1902; *Centralblatt für Chirurgie*, November 29, 1902.

JOHN F. BINNIE (Kansas City).

III. Seven Hundred and Twenty Laparotomies for Gall-Stones. By HANS KEHR (Halberstadt). Kehr's first operation

was performed in 1890, and since that time he has performed 720 operations upon 655 patients. In order to comprehend this subject, he warmly urges the study of the pathology of this affection. This can best be done during operations. He believes that calculi *per se* cause no symptoms. It is only after infection has been added that their presence manifests itself. In 80 to 90 per cent. of his cases jaundice was absent in cases where calculi were lodged in the gall-bladder or cystic duct. Even in common duct stones it was absent in over one-third. Small stones as well as those which attain the size of a walnut remain latent for weeks and even months in the common duct. Both the colic and jaundice are to be ascribed to inflammatory changes in the majority of cases of gall-stones.

A palpable tumor in the region of the gall-bladder is only present in acute, rarely in chronic cases.

Nature's attempts to cure the disease spontaneously are not always the best. He found fistulæ between the alimentary canal and gall-bladder in thirty cases, and in a number of these an ascending infection had occurred. A cure of a case of gall-stones through internal medication seldom occurs. In those cases where such a cure was supposed to have occurred, there had simply been a transition to a latent stage. The Carlsbad waters can create such a quiescent condition.

It is possible to make an exact anatomical diagnosis from the physical findings, the history, and careful observation.

We must be able to determine the location of the calculi and differentiate cholecystitis from cholangeitis, circumscribed peri-cholecystitis from diffuse peritonitis. In cases of chronic closure of the common duct one must be able to distinguish stones from tumors as the cause. In the majority of his cases he is now able to make a special diagnosis.

To be able to form indications for and against operation is another step in advance. He does not operate on every case which he examines. The presence of calculi is not of as great

value as an indication for operation as their sequelæ, for example, inflammation and common duct closure.

In 90 per cent. of the cases of chronic closure of the common bile-duct the stones were too large to have ever been able to pass through the papilla.

He considers operation indicated in acute seropurulent cholecystitis. It is less dangerous than an expectant treatment, if only the pus is evacuated and then the stones removed at a subsequent sitting. His conclusions are:

1. He believes that the medical treatment produces a latent condition in many cases, and in some even a cure.

2. Riedel's dictum to remove the stones as soon as discovered holds now as well as in the past, for it protects against many of the dangerous sequelæ of gall-stones (perforation, cholangia, carcinoma). Such an early operation cannot always be done in practice, hence Riedel's advice is of little practical value.

3. If the attacks are mild and there is complete latency between them, he advises against an operation.

4. Acute closure of common duct is with but few exceptions to be treated medically. If the symptoms of cholangitis become prominent, and the icterus is accompanied by emaciation and anorexia for some time, an operation is to be considered.

5. Frequent colics without icterus or passage of stones, if they cause invalidism, are an indication for operation.

6. Cases of icterus with passage of stones during each attack are an indication for medical treatment, but if they are very frequent and the patient seems to be failing, and there is no prospect of all the stones being passed, he would operate.

7. Hydrops and empyema of the gall-bladder as well as pericholecystic suppuration are in the province of the surgeon.

8. Chronic closure of the common duct should not be allowed to exist too long if a Carlsbad cure has been of no avail.

9. Patients with gall-stones who have become victims of

...

morphine should be operated under all circumstances. During the after-treatment the morphine habit can be cured.

10. Only early operations are of any benefit in carcinoma of the gall-bladder, and these are seldom operated upon early.

11. Patients with chronic icterus, which are not dependent upon a stone in the common duct or incurable diseases of the liver, should be operated upon within three months at the latest, since one will often find a chronic interstitial pancreatitis instead of a suspected carcinoma of the head of the pancreas.

12. Both patient and surgeon will be more easily influenced to operate when a gall-bladder tumefaction, an enlarged liver, jaundice, and fever are present. But even in the absence of local findings, the continuance of severe symptoms is an indication *per se*. One often finds in such cases adhesions without stone.

13. The sequelæ of gall-stones, such as suppurative angio-cholitis, abscess of the liver, perforative peritonitis, subphrenic abscess, severe pyloric and duodenal stenoses as well as ileus due to gall-stones all demand surgical interference.

14. Every case is a unit in itself. Obese patients do not bear operations well. Chronic nephritis, diabetes, arteriosclerosis, pulmonary and cardiac diseases are a contraindication to operation.

Kehr has performed 720 laparotomies upon 655 patients,— 536 of these were women, 119 men. An interesting fact in the table accompanying the article is that of the first 360 operations the majority were cholecystostomies. In the last 360 cases cholecystectomy and drainage of the hepatic duct predominate. Biliary fistulæ no longer follow operations. It may be necessary at times to have temporary drainage of the gall-bladder, but a permanent fistula can be avoided.

In the first 360 cases, 54 per cent. were cholecystostomies; 20 per cent. cholecystectomies; 13 per cent. choledochotomies, and 1 per cent. hepatic duct drainage.

In the last 360 cases there were only 20 per cent. cholecys-

tostomies; 64 per cent. cholecystectomies; 6 per cent. choledochotomies, and 41 per cent. hepatic duct drainages. From this can be deduced that Kehr has

1. Become more radical in his operations.

2. Operated more severe and advanced cases in the last four years.

3. That he restricts the early operations more than formerly.

He prefers cystostomy for all acute processes. In interval operations he believes that the gall-bladder should be extirpated. In removing stones from the common duct, drainage is to be preferred to suture. On account of the fact that stones may remain latent both in the common and hepatic ducts, he has made it a rule in the past year to drain the hepatic duct, and thus avoid recurrence. The mortality of cholecystectomy with hepatic duct drainage is not over 2 to 3 per cent. Adhesions around the neck of the gall-bladder can give rise to the same symptoms as gall-stones. To avoid recurrence in these cases, it is best to extirpate the gall-bladder.

About 10 per cent. of the cases which consult a surgeon have carcinoma. Such patients have no symptoms until the tumor is palpable, and then operation is of no avail. Such a carcinoma is often associated with an empyema of the gall-bladder. In 274 cholecystectomies it was only necessary to reopen the abdomen in one case. At times it is necessary to leave artery forceps *in situ* on account of the inaccessibility of the deeper vessels.

Twelve per cent. of the cases were complicated by gastric affections, principally a stenosis, for which he warmly recommends gastro-enterostomy in preference to other methods (pyloroplasty). In fifteen cases the diseased appendix was removed. He recommends examining the appendix in every case. He makes it a rule to palpate the pancreas, and in case of a diseased organ prefers an anastomosis of the stomach and gall-bladder to any other operation. He anchors the liver (hepatopexy), if hepatoptosis is present, in order to obliterate the subphrenic space.

In 720 laparotomies for gall-stones, his mortality was 15.5 per cent. If one excludes complicating operations such as gastro-enterostomy and hopeless cases such as carcinomata and cholangitis, the mortality would only be 3.5 per cent.

Cholecystostomy was followed by 2.1 per cent., cholecystectomy by 3.1 per cent., and drainage of the common and hepatic ducts by 6.5 per cent. mortality. During the past two years he has lost only 2 per cent. of the common duct cases, owing to more rapid technique, which he considers absolutely essential in this operation. Cholecystectomy is only 1 per cent. more dangerous than cholecystostomy, and has the advantage of being more radical.

If the gall-stone operations are complicated by gastro-enterostomy, the mortality rises to 21 per cent. If complicated by inoperable carcinoma or cholangitis, the mortality is 97 per cent. Even the 3 per cent. recoveries in these cases justify operation. The average mortality of uncomplicated cases of gall-stones is not more than 2 per cent.

The danger of haemorrhage is reduced by the use of chloride of calcium. He formerly taught that patients over sixty should not be operated, but he now believes that this is no objection. Similarly chronic icterus due to closure of common duct is no objection, because in many cases a chronic interstitial pancreatitis is thus relieved, as Mayo Robson has shown. He advocates the combination of drainage of hepatic duct with cholecystectomy as the normal method. He opens the common duct in its supraduodenal portion, and then inserts a drainage tube a distance of about two inches into the hepatic duct, and the entire bile is led to the surface for about fourteen days, without interfering with digestion in the least. This procedure is much less difficult than a suture of the common duct and not so apt to overlook stones.

He places gauze tampons around the tube leading to the hepatic duct. He has never observed fistula or stenosis or ascending cholangitis following hepatic duct drainage.

One is less apt to have recurrences with radical operations. He has never observed a genuine recurrence. Frequently stones are overlooked or colics due to adhesions follow operations. This is far less likely if the gall-bladder is extirpated.—*Münchener medicinische Wochenschrift*, Nos. 41; 42, and 43, 1902.

DANIEL N. EISENDRATH (Chicago).

IV. Injuries of the Spleen and Liver. By H. ROESER (Carlsruhe). The injuries of the spleen are classified by the author as laceration of the capsule, subcapsular haematoma, and rupture of the spleen, any one of which may be accompanied by injury to other abdominal or thoracic viscera.

For the lesser injuries, sutures deeply passed into the parenchyma may control the bleeding, or the Pacquelin cautery or vaporization. Where the laceration is extensive, extirpation must be practised. Of 135 ruptured spleens, 104 died; ninety without operation. Of thirty subjected to the operation of extirpation, sixteen recovered,—53 per cent.

The consequences of splenectomy are a transient diminution of the red blood-cells, increase of the leucocytes. The thyroid is not vicariously enlarged. The lymph nodes and the bone marrow show increased haematogenic properties. There is a diminution of the haemoglobin. Splenectomy is followed by no permanent lesions.

A median laparotomy is favored as the best route to gain access to the spleen. A saline intravenous infusion should precede the operative interference. The vessels of the hilum should be separately tied, and preferably with silk, to guard against slipping. Two cases are narrated of subcutaneous rupture of the spleen for which splenectomy was practised.

For injuries of the liver, suture remains as the best procedure to control haemorrhage. Catgut and wholly rounded needles had best be employed. The suture should embrace a wide extent of liver substance. If the laceration be very extensive,

tamponade is to be practised. The Pacquelin cautery is only of service in slight parenchymatous hæmorrhages and vaporization likewise. If the large veins be injured, they should be sutured. Injury to the biliary passage should be sought for and remedied by suture, if possible.—*Beiträge zur klinischen Chirurgie*, Band xxxvi, Heft 1.

V. Transpleural Laparotomy for Stab Wounds of the Spleen. By DR. F. SHAEFER (Strasburg). Subsequent to a penetrating wound of the abdomen, we may decide that intra-abdominal hæmorrhage is at hand, but we can only presume from the locality of the wound inflicted that the spleen has been affected. Yet, two observers, Fevrier and Trendelenburg, have directed attention to a tetanic condition of the abdomen extending to the cremaster muscle, thus drawing up the scrotum and the penis. Trendelenburg attributes this tetanic condition of the abdomen to the chemical as well as the mechanical irritation of the blood upon the peritoneum. This sign is by no means always present, and only derives significance in the presence of an acute anæmia. As to dulness, this is a more valuable yet erratic sign, since the blood may gather in the omental bursa, or, if the diaphragm has been injured, the respiratory movements of the lung may aspirate the blood into the pleural cavity. Thus there will be intermissions in the hæmorrhages, and the secondary hæmorrhages will only prove fatal after the lapse of days.

Seventy-one open wounds of the spleen are analyzed; twenty were operated and recovered. Of fifty-one not operated, one recovered. Hence the dictum, every penetrating wound of the spleen is a strict indication for an operation.

Statistics show that in a great majority of the cases the route of the wound is *via* the thorax, and furthermore that wounds of the spleen are complicated with wounds of other organs. In stab and gunshot wounds coming from the left side, the pleural cavity and diaphragm are injured.

If the external wound be in the abdominal region and access to the spleen and diaphragm is difficult, then the dread of occasioning an acute pneumothorax is not to be taken seriously into consideration in choosing the transpleural route; and if the external wound overlies the lower thoracic wall, a transpleural laparotomy is all the more so indicated. It consists in a section of several ribs, and then making these ribs hinge at their cartilaginous junction. The advantage of such a transpleural flap is the better access thus afforded to the upper lateral parts of the abdomen and the greater facility obtained in treating the injury to the diaphragm. This is the contention of surgeons who have taken this route to attack the injured spleen. A weakening of the abdominal wall is thus avoided; the chest wall suffers no more than is experienced in resection for empyema. The dangers of pneumothorax are overestimated, since many patients are already in this condition; and even were they not, the dangers arising from peritonitis setting in are greater than those of pneumothorax.—*Beiträge zur klinischen Chirurgie*, Band xxxvi, Heft 1.

MARTIN W. WARE (New York).

EXTREMITIES.

I. Hard, Traumatic œdema of the Dorsum of the Hand and Foot. By DR. VULLIET, Lausanne. The disease is more frequent in the hand than the foot.

1. Etiology. Usually a well localized blow on the back of the hand (not necessarily severe); more rarely dorsal flexion of the hand.

2. Symptoms. During the first days after the trauma, diffuse swelling of the dorsum of hand or foot, most marked at the base of the fingers or toes. At the height of the disease, the swelling is hard, elastic; no pitting on pressure. The skin cannot be pinched up in folds. There are no signs of inflammation and no ecchymosis. Here and there crepitation may be noted. The ball of the thumb is normal. Skiagraphs show the bones un-

injured. Pressure is painful; active and passive movements of the fingers are hindered, are often very painful (especially when over-extended); the thumb is always unaffected.

3. Course and termination. For a time the swelling remains unchanged, then subsides slowly in the course of eight to twelve weeks, though it often persists longer, in which case one notices either a hard, well-defined nodule or a diffuse induration on the bones. These indurations are rarely permanent, and remind one of a fracture or chronic inflammation. While the hand can be used before the swelling has entirely disappeared, yet work is not recommended while any swelling persists.

4. Pathogenesis. In the absence of direct anatomic investigation, it is assumed that the condition is one of fibrous, diffuse exudation, which is slowly absorbed and in places is organized.

5. Differential diagnosis. Inflammatory oedema resulting from infection presents marked symptoms; it is soft, red, shows a source of infection, and causing glandular swellings. The oedema from circulatory disturbances is also soft. Fractures of the metacarpal bones give more localized symptoms, have ecchymoses; the duration of the swelling is not so long and callus forms. Skiascopy completes the diagnosis. Effusions of blood always show ecchymoses, which are never seen in "hard oedema."

The diagnosis may become difficult when the hard, diffuse oedema persists longer than usual, or, if persistent, indurations or nodules form on the metacarpal bones.

6. The treatment consists in warm baths. Massage seems to do more harm than good. Elastic pressure has no influence.—*Centralblatt für Chirurgie*, 1902, No. 43.

JOHN F. BINNIE (Kansas City).

II. Tenoplasty in the Treatment of Flat-foot. By PROFESSOR DR. ERNST MÜLLER (Stuttgart). Flat-foot has been treated by numerous methods of operating on tendons: Shortening of the tibialis posticus (Hoffa, Francke), union of the tibialis

anticus to the under surface of the first metatarsus (Francke), transplantations of a part of the tendo Achillis into that of the tibialis posticus (Nicoladoni, etc.). The author gives a new method, and recommends it highly. His method consists in the separation of the tendon of the tibialis anticus from its insertion and its union to a canal in the navicular bone. He has done the operation thirteen times on seven patients. The *modus operandi* is as follows: Curved incision along the margin of the arch of the foot, beginning behind and below the internal malleolus midway between this and the sole, and ending anterior to the base of the first metatarsal. Find the insertion of the tibialis anticus tendon in the anterior angle of the wound, divide it and isolate it up to the region of the ankle. Expose the lower surface of the arch of the foot for the space of one centimetre outward, and with a trephine the size of a lead-pencil bore a hole through the navicular bone from below upward and somewhat backward. Pull the tendon through this hole by means of a thread. Press the arch of the foot upward as far as possible, pull the tendon strongly downward, and, slinging round the inner margin of the navicular bone, fix it there to the bone by means of wire sutures. The arch of the foot will be held up by the tendon as if by a bridle. Apply a plaster dressing for four weeks, then use massage to the leg and passive movements; soon careful rising movements may be practised; but the "flat-foot sole" must be used until the muscles become sufficiently strong. As a preliminary step in the operation, the tendo Achillis ought to be divided, otherwise it will be impossible to push the arch up high enough in supinated feet. The author considers the condition of the tendo Achillis very important in flat-foot, its contraction being sufficient to cause the trouble in some cases, and he has divided it with good effect. If the tendon is too short, there cannot be sufficient extension in the talocrural joint to permit the foot assuming a right or acute angle with the leg; but if this takes place during walking or standing, then the weight of the body elevates the anterior part

of the foot and causes plantar flexion of the posterior part, thus causing flat-foot. The tenoplasty as above described is specially indicated in those cases of flat-foot where the tendon of the tibialis anticus stands out as a cord. This sign is usually described merely in cases of contracted flat-foot where there is a spastic condition of the muscle, but it may very frequently be seen in mobile flat-foot, where its presence may be indicated by pigmentation of the skin over the course of the tendon.—*Centralblatt für Chirurgie*, January 10, 1903, page 40.

JOHN F. BINNIE (Kansas City).

REVIEWS OF BOOKS.

THE SURGICAL DISEASES OF THE GENITO-URINARY ORGANS.

By E. L. KEYES, A.M., M.D., LL.D., Consulting Surgeon to Bellevue Hospital, etc., and E. L. KEYES, JR., A.B., M.D., Ph.D., Lecturer on Genito-Urinary Surgery, New York Poly-clinic School and Hospital, etc. Pp. 827. D. Appleton & Co., 1903.

"Van Buren and Keyes" has so long been a standard authority that every physician has more or less acquaintance with at least the outlines of the book. But a new generation of practitioners has come since the edition of 1888, and changes have taken place in surgery and medicine to such an extent that the present work is to all intents and purposes new.

The plan of the book is more distinctly surgical and less venereal than the previous edition. Syphilis and the sexual disturbances are mentioned, but not treated of at any length; although a generous space is devoted to gonorrhœa, as the cause of so many genito-urinary troubles; and even its more remote manifestations and complications are considered with much detail. Some fine colored plates are inserted illustrating the gonococcus and the method of differentiating the true from the false micro-organism. In passing, a word of praise is due the many excellent illustrations with which the book abounds. It is not feasible to more than indicate a few of the many excellences of the work, for a review must be rather a taste than a full meal.

Such important subjects as urethritis, cystitis, vesiculitis, inflammations of the epididymis and testicle and other allied conditions are considered thoroughly and authoritatively. The same may be said of vesical calculi. Litholapaxy, however, which many surgeons have relegated to oblivion, is described at length and heartily advocated.

The chapters on the surgery of the kidneys and ureters are full, plain, conservative, and thorough. The causes of floating kidney are considered in detail, and Einhorn is quoted in substantiation of the statement that gastric symptoms are not due to the prolapse. Nevertheless, several observers have recently called attention to the fold of peritoneum which passes from the right kidney to the pylorus and upper duodenum, and which undoubtedly drags upon those structures when the kidney descends. Such traction must of necessity exert some harmful action on the digestive apparatus.

We approach with something more than passing interest the section dealing with surgical diseases of the prostate, and especially the radical treatment of obstructive hypertrophy, for this subject, requiring as it does so ripened a judgment, and being influenced by so many factors, is dealt with differently by almost every surgeon. Laying aside all comment on when to operate, and taking into consideration only the method to be employed, we find a marked preference on the author's part for Chetwood's perineal galvanocautic operation, which is essentially Bottini's, but performed through a perineal incision with a specially modified instrument. It would seem that the objections urged against Bottini's operation might fairly be urged against Chetwood's. The removal of tissue by burning, and waiting for the slow separation of sloughs with subsequent shrinkage, carries one back to the days of Ambroise Paré and his revolt against the cautery. Further, the lowering of tissue vitality by burning, in an area already teeming with pathogenic bacteria, seems to invite infection. Again, the perineum is perforce incised in this operation. Why not be a bit more generous, enlarge the incision sufficiently to *see*, and then with knife, scissors, forceps, and fingers enucleate the prostatic tissue, and accomplish at once what cauterization may altogether fail of? Perineal prostatectomy presents all the advantages claimed for other methods, and, above and beyond everything, it is simple, surgical, and sufficient.

Among many other excellent features there should be emphasized a diagnostic table in which penile chancre, chancroid, herpes, and simple ulcerated abrasions are compared in parallel columns. It should be very helpful in many cases of obscure origin.

Page 187 assures us that "some are born with stricture; . . . some acquire stricture; . . . and, alas! many have stricture thrust upon them!" May we hint a doubt as to whether Malvolio would altogether enjoy the paraphrase of his famous soliloquy? And is "laboratorially" permissible? On the whole, however, a book which carries so strongly the impress of its authors' personality and is withal so broad and fair minded deserves more than ordinary commendation.

HENRY GOODWIN WEBSTER.

SURGICAL DISEASES OF THE KIDNEY AND URETER, including Injuries, Malformations, and Misplacements. By HENRY MORRIS, M.A., M.D. (Lond.), F.R.C.S. Two volumes, 8vo, 600 pages each. Chicago, Ill.: W. T. Keener & Co.

These two volumes are to be considered as an extension and elaboration of Mr. Morris's original manual on "Surgical Diseases of the Kidney," published in 1884. Since 1884 renal and ureteral surgery have developed to a remarkable degree, and the author, with increasing interest, has kept pace with the advance, adding to his own experience, and studying zealously the work of others.

The scope of the two volumes is defined in the preface, and embraces a systematic account (1) of the regional anatomy, the malformations and misplacements, and the injuries and surgical diseases of the kidney and of the ureter; (2) of the affections of the perinephric and the peri-ureteral tissue; and (3) of the surgical treatment of these several conditions as recommended and practised at the present time by those most occupied in this branch of surgery.

Volume I is entirely devoted to the kidney. In discussing the

clinical examination of the kidney, Mr. Morris is not enthusiastic over the methods at present in vogue. The X-ray he holds as unreliable, shadows being cast when no calculus exists, and *vice versa*. He does not place much reliance on cryoscopy, and gives rather a wider margin than most authors, stating that when the freezing point of urine is below 0.9° C. renal insufficiency is indicated. Other observers, however, have established the standard between 1° and 2° C. as the index of renal sufficiency. The methylene blue test he considers as unreliable, since certain hepatic and nervous disorders as well as compensatory hypertrophies of the renal parenchyma affect it considerably. The phloridzin test is mentioned, but the author does not express any opinion as to its usefulness.

Each chapter is introduced by a short history of the subject to be considered, and reference is made to the principal memoirs on the subject. An exhaustive bibliography, however, is not given.

The chapter on movable kidney is very instructive. Its pathology is thoroughly discussed and the associated phenomena are explained. Nephropexy as a means of cure he likens to the operation for the radical cure of hernia. It is especially indicated, he states, where pain and gastro-intestinal symptoms predominate. In cases of renal crises, nephropexy is strongly urged. When complicated with hysteria and neurasthenia, the results are doubtful.

The subject of the treatment of haemorrhage from an injured kidney is presented in an exhaustive *résumé* of the subject, and cannot fail to impress the reader with the thoroughness and conservatism with which Mr. Morris attacks the consideration of interference in renal disease. He accepts the statistics with caution. He says in part: "The argument is, I think, fallacious which assumes that the cases which have been operated upon are the most severe, and those not operated upon are the slighter injuries; and so also is the conclusion that if many of those

treated palliatively had been operated upon, the mortality would have been very materially further reduced."

In considering the pathology of the various diseases, his description is most complete, and presents all of the various pathologic forms which the disease may assume.

Volume II consists of two parts,—Part I being a continuation of his treatise on renal surgery, while Part II is devoted entirely to the surgical diseases of the ureter.

The various methods of examining the ureter are taken up in Chapter III of the second part. Palpation, inspection, and catheterization of the ureter are discussed at length.

Mr. Morris takes issue with most of the enthusiasts on ureteral catheterization. His objections are: 1. The obnoxious nature of the operation in the female, and the extreme difficulty of it in the male. 2. The unreliableness of the information it affords. 3. The risks to which it exposes the patient. 4. The disadvantages of it as a mode of treatment.

All of his teachings are founded upon sound and scientific surgical principles, and the two volumes cover well the entire field of renal and ureteral surgery.

PAUL MONROE PILCHER.

REGIONAL MINOR SURGERY. By GEORGE GRAY VAN SCHACK, M.D., Attending Surgeon to the French Hospital, New York. New York: Published by the International Journal of Surgery Co.

This little volume deals with minor surgical emergencies and diseases, the treatment of which usually falls to the lot of the general practitioner.

The principles embodied are thoroughly sound and modern and the result of an extensive experience in both hospital and private practice.

The opening chapters are given to the consideration of asepsis, dressing, and the suturing of wounds. Then each region of

the body is in turn considered, and the injuries and diseases to which it may be subject are described with special reference to the various methods of treatment which may be employed.

The chapters on the affections of the hand and fingers is particularly comprehensive. The writer well states in the preface that "minor surgery is minor in name only," and that much of this class of surgical work is in the hands of the general practitioner, "who will be judged more often by his results with an injured finger than by those which he achieves with so much arduous labor in internal medicine and obstetrics."

In the reading of this little book one cannot fail to get many new and useful ideas. There are numerous good illustrations, and, on the whole, it serves admirably the purpose for which it is intended.

WALTER A. SHERWOOD.

THE ELEMENTS OF PATHOLOGICAL ANATOMY AND HISTOLOGY.

By WALTER SYDNEY LAZARUS-BARLOW, B.A., B.C., M.D.
(Camb.), F.R.C.P. (Lond.). Philadelphia: P. Blakiston's
Son & Co., 1903.

The work is primarily a text-book, and aims to place before the student a treatise in which the typical pathological lesions are emphasized, rather than the sub-varieties.

The author's view as to illustrations is certainly the correct one, for he claims that a student needs special training to properly interpret microphotographs, while accurate drawings are of much greater value, since they depict more clearly the existing conditions. The drawings of microscopic sections have been faithfully executed and are a distinct feature of the book. The same criticism cannot apply to the illustrations of gross sections; and it is believed that actual photographs could be used to better advantage.

The author does not delve deeply into the various theories of pathologic change, but states simply the most generally accepted facts.

The subject-matter is well arranged, introducing in the first part the general pathological anatomy and histology of the tissues, and then taking up in the second part the pathological anatomy and histology of the special organs and tissues.

The author expresses himself clearly and concisely, and in addition possesses a style which holds the interest of the student, at the same time emphasizing the essential features.

PAUL MONROE PILCHER.

THE AMERICAN YEAR-BOOK OF MEDICINE AND SURGERY. Surgical Volume, 1903. Under the general editorial charge of GEORGE M. GOULD, M.D. Philadelphia: W. B. Saunders, 1903.

The title-page of each issue of the "Year-Book" presents changes in the personnel of its editing staff; changes that remind us that some eminent contemporary has completed his scientific work among us, or that one must limit his hours of labor as "sunset days" replace the time of ceaseless activity and enthusiasm. As ever, Dr. Gould exhibits excellent scientific judgment in the selections of new collaborators, and the work goes on increasing in size and in importance. The "local flavor," remarked some years ago in review, persists and becomes more decided. In theory this is not wise editorially, scientifically, or commercially. *The American Year-Book* should number among its editors men of eminence from *every* important *American* medical centre (New York, Philadelphia, Boston, Brooklyn, Ann Arbor, Baltimore, Washington, Chicago, Cleveland, Buffalo, New Orleans, Denver, San Francisco, Montreal, and Toronto). The editorial spices synthetically formed by the combination (and competition) of literary geniuses widely distributed would add zest and vigor to the product. The multiplicity of points of view would enlarge its scope. The commercial advantages of such a policy are clear.

In the volume before us the surgical section has been enlarged to 339 pages. It seems more complete than any of its

predecessors, although its recapitulations are brief enough. Work on surgical technique is clearly abstracted. The paragraphs on tetanus are of great interest. There are many reviews of writings dealing with studies of tumors. These studies are based largely on clinical observations. Gastric and enteric surgery, operations upon herniæ, and recent acquisitions to our knowledge of appendicitis are treated at length. Extensive surgical work in the cranial cavity is reported. Taking the section as a whole, it is very satisfactory. In the section on obstetrics, we find a discussion of the midwives question on the first pages. This is followed by some startling disclosures regarding the increasing sterility among American women. Then are recorded case reports, clinical observations, and descriptions of new methods in profusion. Dystocia has been the theme of many writers here reviewed. The year's gynaecological literature is well presented, although, from the excessive proportion of foreign works mentioned, we would deduct that many American writings have been passed unnoticed. Brief and concise are the offerings of the orthopædists. There is little of interest in the section devoted to the eye. The logical merging of the departments given to the ear, nose, and throat is ventured for the first time in this volume. The pages on anatomy are more numerous than in past years. The index is a good one. Illustrations seem proportionately fewer than before. This is surprising when the art is advancing so rapidly. The increasing frequency and improvement in execution of illustrations is a beautiful feature of most modern scientific literature.

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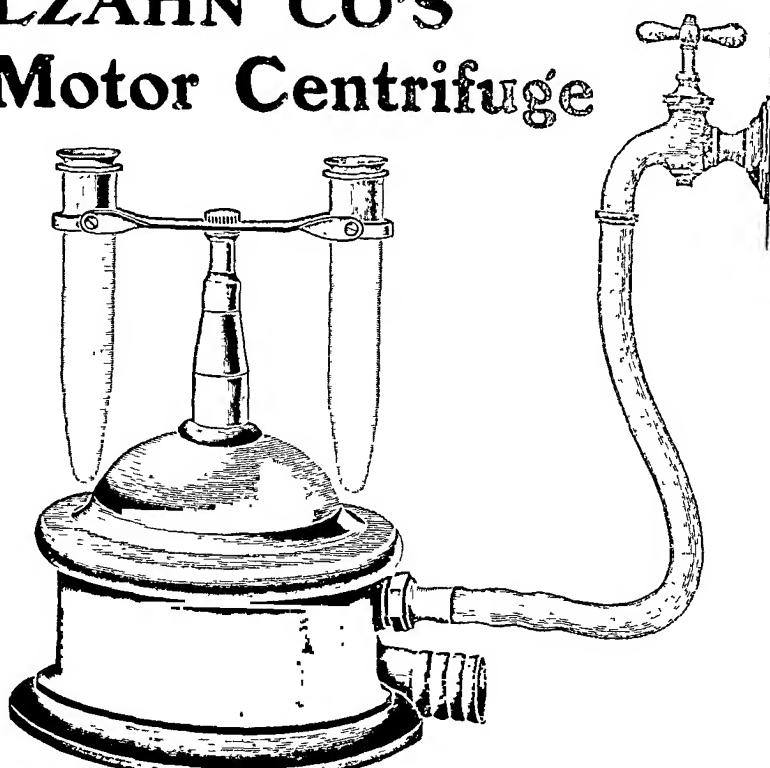
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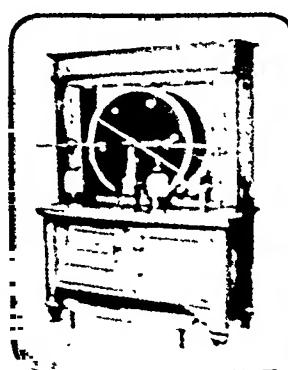
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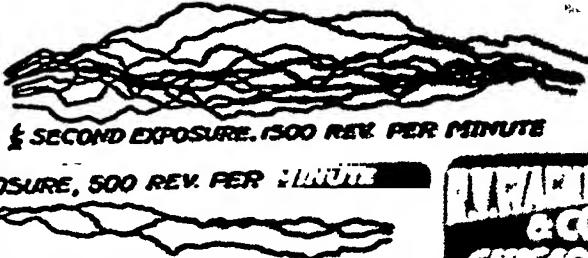
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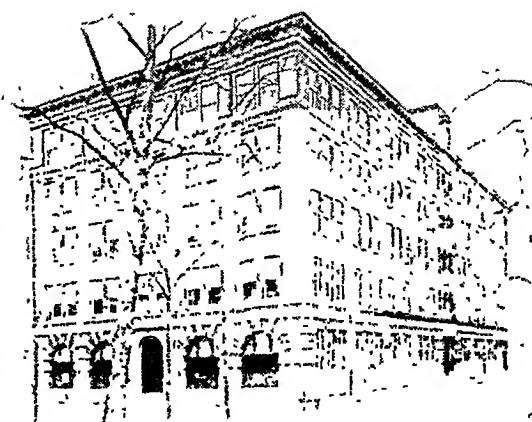
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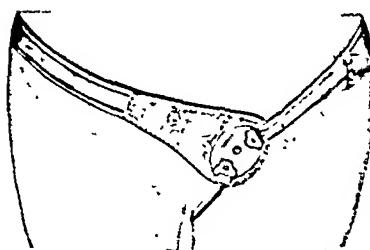
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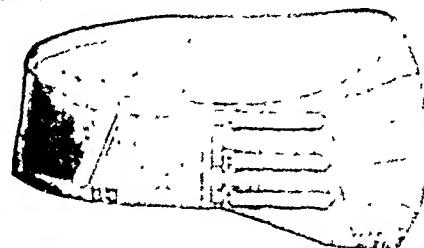
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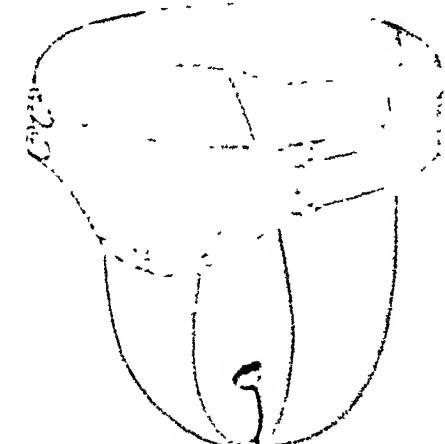
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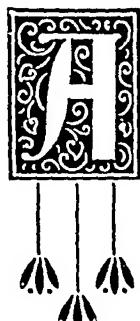
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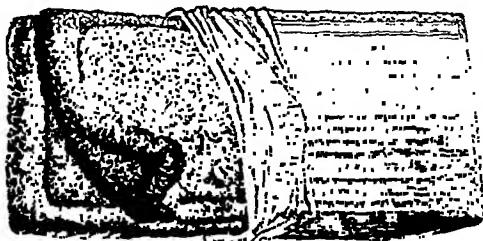
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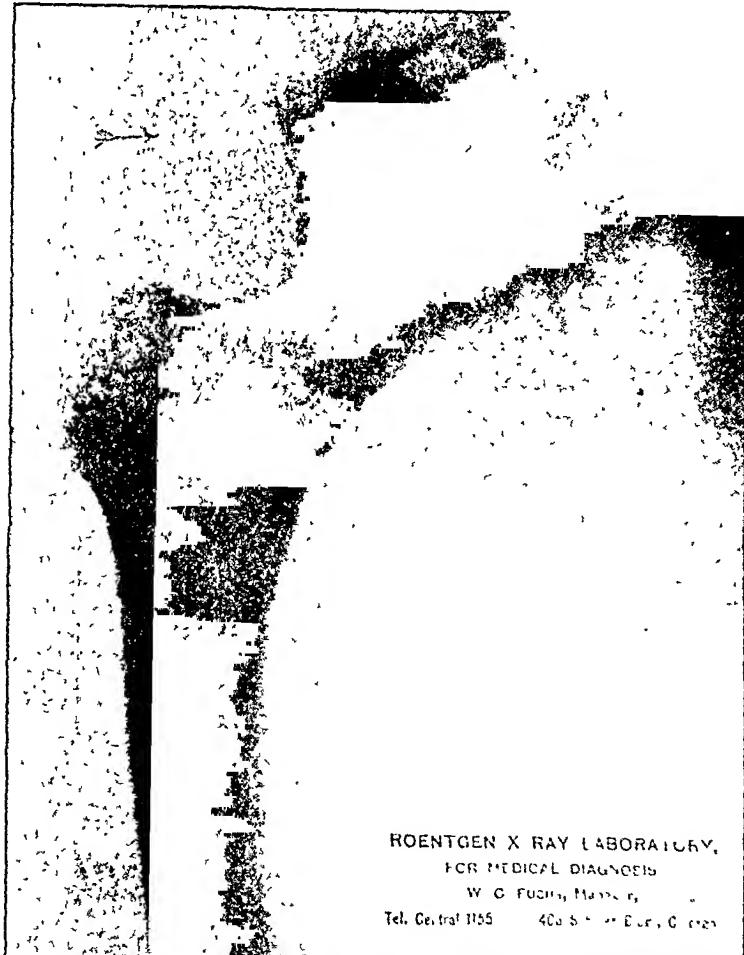
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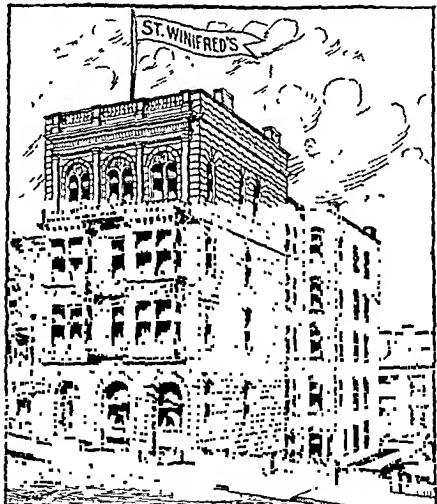
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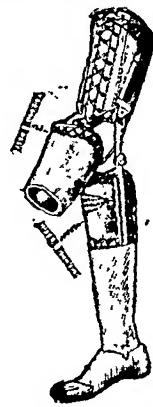
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ORIGINAL MEMOIRS.

OPERATIVE POSSIBILITIES IN CASES OF ADVANCED CARCINOMA OF THE BREAST.*

BY LEWIS STEPHEN PILCHER, M.D.,

OF NEW YORK,

Surgeon to the Methodist Episcopal and to the German Hospitals in Brooklyn.

THE history of adequate attempts to satisfy the indications presented by the pathology of carcinoma of the breast in operative procedures for its removal is brief and very recent; practically, it is included within the surgery of the past twenty-five years. Up to the beginning of this period, a feeling of hopelessness filled in general the surgical mind when confronted by cancer of the breast, since the ablest surgeons found themselves compelled to acknowledge the ultimate failure, in almost every instance, of their efforts to eradicate the disease by operation. In 1867, Charles H. Moore¹ had read a paper before the Royal Medical and Chirurgical Society of London on "The Influence of Inadequate Operations on the Theory of Cancer," in which he urged the importance of removing together with a diseased breast any texture adjoining the breast which is even approached by the disease, especially skin, lymphatics, fat, and pectoral muscle. This paper contained the germ of an advance in the surgery of the breast, the development of which became evident ten years later in the first paper published by Mr.

* A paper contributed to the Festschrift in honor of Professor Victor C. Vaughan, of the University of Michigan.

Mitchell Banks,² of Liverpool (1877), in which was definitely formulated the teaching that, whenever there was found an appreciable disease in the breast, the axillary lymph nodes were to be regarded as already involved in the disease, and that, whether enlarged glands could be detected by palpation or not, the fatty and glandular contents of the axilla should be systematically cleared out in all cases as a part of the operation for the removal of a cancerous breast.

Nearly simultaneous with this movement among English surgeons was a similar and even more general departure by their colleagues in Germany, marked especially by the writings of Volkmann³ (1882) and of Küster⁴ (1883), who to the systematic clearing out of the axilla added the practice of carefully dissecting from the surface of the pectoralis major muscle the fascia which covers it. In the United States, also, the younger Gross, particularly, by his papers and by his work on "Tumors of the Mammary Glands" (1880), was emphasizing the importance of a wider extirpation of possibly infected neighboring tissues and lymph glands.

A more important step was made in 1889, when Heidenhain⁵ made a report to the German Surgical Congress, in which he demonstrated the pervasiveness of the carcinomatous process throughout the whole of a breast in which any part was affected, and the extension, as a rule, into the underlying fascia of any carcinomatous process in a breast, however limited it might seem to be. He further demonstrated the impossibility of removing this fascia without leaving behind disease-bearing fragments of it, however careful may have been the attempts to dissect it away from the subjacent muscle. Thus was explained the frequency of local recurrence, even after the most painstaking removal of this fascia.

The logical inference was that the pectoralis major muscle, as well as the fascia covering it, should be removed, together with the overlying breast and the axillary contents, in every case of carcinoma of the breast, in order to insure the highest possible certainty of complete removal of the disease in any given case.

In 1894 was made the first publication by Halsted⁶ of the unusually favorable results which he had been able to secure at the Johns Hopkins Hospital by a careful and thorough carrying out in his work of the precautions suggested by his predecessors as already named; adding, as the special feature of his own work, a more free removal of the overlying skin, and a more frequent invasion of the region above the clavicle.

During the earlier years of the work which the writer was privileged to do in Brooklyn, namely, in the period extending from 1872 to 1888, his work in connection with mammary cancer was conducted on the lines until then generally taught and practised by surgeons, and which he now recognizes as having been incomplete. The record of his cases during this period is not complete enough for him to make use of them for statistical purposes. As a whole, however, they were a dreary record of recurrence, with quickly following death. In some instances, however, the advantage gained by his operations was so marked as to stimulate him to continued efforts, and to make him the more ready to adopt the more radical measures of the surgeons, whose work has just been referred to, when they were brought to his attention.

In one case, after the removal of a breast, followed later by a removal of perceptibly large axillary glands, the patient survived for six years, finally dying with symptoms indicating carcinoma of the liver.

In a second case, which presented itself to him with recurrence in the scar made by another surgeon, with well-marked involvement of axillary and supraclavicular glands, after a very free extirpation of all the diseased structures, in the course of which the internal jugular and subclavian veins and the axillary artery were ligated, the patient remained free from local recurrence, and enjoyed six years of good health; but then evidences of intrathoracic disease manifested themselves, terminating in death two years later.

When, by the opening of the Seney Methodist Episcopal Hospital in 1887, the writer was placed in a position to do more systematic work, and to preserve the records of the same,

he endeavored to take advantage of the opportunities presented, and the present study is based, with one exception, upon the cases which have come under his care in that institution during the period from 1888 to 1900 inclusive. The operations recorded were in most instances made by himself personally; in some cases they were conducted by his assistant, Dr. Warbasse.

In reviewing any series of cases of carcinoma of the breast with reference to the value of the measures instituted for their relief, it is of the highest importance to classify the cases according to the nature and extent of the disease presented by them.

All cases in which operations have already been done, and which afterwards present themselves with recurrence, more or less wide-spread, constitute a category entirely distinct from those cases in which the primary growth is met with as yet undisturbed by any surgical procedure.

In the mentioned class a long-standing existence of the disease is certain, together with evident wide-spread diffusion of the disease elements; a condition carrying with it almost a certainty that multiple points of disease exist not yet sufficiently developed to be grossly perceptible in addition to the nodules which are already palpable.

Efforts at a radical removal, therefore, are extremely likely to be incomplete, and to be followed speedily by the appearance of further points of disease.

Numerous cases of such secondary operation have engaged the efforts of the writer during the period under consideration, but in no case has ultimate success been attained thereby. With this reference to them, and this admission, they are excluded from further consideration in the present study.

The number of primary cases which seemed to promise benefit from operation which have presented themselves during the period in question was exactly fifty. All of these were subjected to operation. In seven of them, however, the operation itself revealed that the disease had already extended beyond the possibilities of entire removal, either by reason of the degree

to which the wall of the thorax was plainly involved, or by reason of the evident extension of the disease to the mediastinal glands.

In one of these, in which a portion of a rib was removed in the course of the operation, a pneumonia developed, which proved fatal on the third day. This was the only fatality attributable to the operation in the whole series. There remain, therefore, forty-three cases in which supposedly complete extirpation of a cancerous breast and adjacent disease was done.

It is hardly necessary to premise that in all cases the operative attack that was made was guided by a desire to go so wide of the disease that no vestige of affected tissue should be left behind.

Still, in dealing with carcinoma in any region of the body, the surgeon ever finds it difficult to hold a just balance between the natural reluctance to unnecessarily sacrifice apparently healthy tissue, to inflict unnecessary deformity and disability, and to increase to an unnecessary degree the hazards to life that attend his work, and the demands for radical, wide-extending extirpation arising from the unquestioned fact that a wide margin of apparently healthy tissue of indefinite extent must always be regarded as already invaded by microscopic disease elements, disseminated along the lymphatic paths that lead from the recognizable grossly affected foci. Too often the later history of his cases shows him that what was intended to be judicious conservatism was really imperfect and useless surgery, that had tended greatly to lessen the original possibilities of ultimate cure. Be this as it may, it is my desire now to record the actual results attained, and to draw from them such lessons as may seem warranted thereby.

In all the cases the general procedure was conducted in accordance with the teaching that the incisions through the overlying skin should go wide of apparent disease, and that the breast and axillary lymphatics, with the connective tissue and fat in which they were embedded, should be dissected out as an unbroken piece.

In looking over the details of the technique employed in

the carrying out of this general plan in the several cases, they naturally divide themselves into the following classes:

I. Ablation complete to apex of axilla, without removal of any pectoral muscle. Two cases.

II. Ablation complete to apex of axilla, with removal of pectoralis major muscle only. Eleven cases.

III. Ablation complete to apex of axilla, with removal of both pectoral muscles. Twelve cases.

IV. Ablation complete to apex of axilla, with removal of one or both pectoral muscles, and invasion of the supraclavicular region. Eighteen cases.

Of the two cases in Class I, the first remained well for six years after operation, when symptoms of intrathoracic disease developed, which proved fatal within the year.

In the second case, a local recurrence in the border of the pectoralis major muscle had developed eighteen months later, for which a second operation was done, when the whole muscle was removed. The patient remained well for five years, when a similar disease appeared in the other breast. This second breast was then removed, together with the contents of the axilla and the pectoralis major muscle on that side. No further recurrence of externally located cancer took place; but after three years, symptoms of cancer of the liver developed, resulting in death ten years after the first operation for mammary disease.

In Class II, the first case, at the end of ten years, still remains well.

The second patient died of cerebral apoplexy one year after operation, having had no sign of recurrence up to the time of her decease.

The third case, at the end of eight and one-half years, remains well.

The fourth case remained well for six years; during the seventh year there became evident carcinoma in the ribs, behind the site of the primary disease. This has very slowly advanced, and the patient is still living, though in feeble health, nine years after operation.

The fifth case, at the end of eight years, remains well.

The seventh case died two years after operation from intrathoracic metastasis.

The eighth case is the one mentioned in the preceding class, in which disease appeared in a second breast six and one-half years after the removal of the first breast for cancer, and in which case ultimate death resulted three and one-half years after the last operation from supposed carcinoma of the liver, no local recurrence having taken place.

In the ninth case, six months after operation the supra-clavicular glands were perceptibly enlarged; the space above the clavicle was then cleaned out, but it was then found that the disease had extended into the mediastinum. Death followed within two years.

In the tenth case, the patient was well one year after operation, since which time no report has been obtained.

The eleventh case died two years after operation with local and regional recurrence.

In these two classes,—Classes I and II,—of the thirteen patients contained in them, the later history of all but one being known, it appears that four have remained well to the present time, periods of from eight to ten years having elapsed since operation; that three more enjoyed a period of immunity lasting for six years, and then in each case developed renewed cancerous disease; that in three cases evidences of recurrence, in distant regions, showed themselves within three years after the operation, and that in but two cases did local recurrence take place.

It is pertinent and important to remark as to these cases that they comprise those in which, of all those which presented themselves for treatment, the disease apparently had made the least advance; in which no muscular involvement was detected, and in which the involvement of the glands of the axilla was not so extensive as to make difficult the cleaning out of that space. In three of the cases, however, the result showed that the primary operation was not complete, namely, the second case of Class I, in which the pectoralis major muscle was

not removed, and in which muscle the disease developed within a few months after the primary operation; in the ninth case of Class II, in which, within a few months after operation, the supraclavicular glands became noticeably enlarged, and were then attacked, but, as the operation revealed, not until after the disease had extended into the mediastinum; and in the eleventh case of the second class, in which within a year such extensive local recurrence had developed as to make any further operative effort impracticable.

That so large a proportion of absolute recoveries, or of freedom from disease for many years, should have been secured by the operative measures employed is full of encouragement as to the possibilities of successful attack in the earlier stages of breast carcinoma.

On the other hand, one cannot but harbor the thought that if a wider excursion to the operative attack had been made at the first in the last three cases mentioned, such as the removal of a greater area of skin, of the pectoralis minor muscle, and of more of the axillary connective tissue, and the extension of the incisions above the clavicle, the number of definite cures might have been yet larger.

This experience serves to confirm the value of the more recently advocated methods of dealing with carcinoma, the results simply being in accord with those which have been secured by many other surgeons working on the same lines.

With Class II comes into consideration cases in which the disease had attained a more advanced stage, so that, in order to facilitate the thorough removal of the axillary contents, the pectoralis minor muscle was removed as well as the pectoralis major.

The character of the results obtained by operation present a most marked change from those presented by the preceding classes. Twelve cases are included in this class. In one case the later history is unknown; of the remaining eleven, one lived five and a quarter years after the operation free from recurrence, and then died from an acute pneumonia at the age of seventy years. Two others are well at the present time, three

years and three years and four months * respectively after the operation. One is living five and a half years after operation, but with slowly advancing recurrence in axilla and above the clavicle. One other is still living three years after operation without external recurrence, but with evidence of carcinoma of liver. Six patients have died at periods varying from twelve months to five years and a half after operation. In all but one of these cases the development of supraclavicular disease was among the earliest evidences that the primary operation had been incomplete. In so many instances did this demonstration of the extension of the disease to the lymph glands above the clavicle occur, notwithstanding no such glandular involvement was perceptible to examination, that it has seemed to the writer to be reasonable to regard the supraclavicular lymphatic tissues as diseased in all cases in which the glands at the apex of the axilla were markedly affected, and that in all such cases the rational procedure for the surgeon to pursue was to open up the supraclavicular spaces and clean them out as well as to deal in the same manner with the axilla. Accordingly, in a very considerable number of cases, notwithstanding the absence of any evident supraclavicular disease, that region was opened and explored. The number of such cases was eight, and in nearly all of them were uncovered and removed small nodules distinctly cancerous, though too minute to be detected by palpation when covered by the intact fascia and skin. The total number of cases in which the supraclavicular spaces were opened is eighteen, in ten of whom palpable supraclavicular nodes existed. Of the entire number of this class, Class IV, but two have remained well. These two cases have now passed respectively six and four and a half years since operation in good health, entirely free from any suggestion of cancerous disease. One other still lives, more than two and a half years since operation,

* Shortly after the preparation of this report, this patient was found to have a small pea-sized movable nodule in the connective tissue under the scar in the fourth intercostal space in the mammillary line. This was at once excised with much circumjacent tissue under cocaine, October 29, 1902.

in good general health, but with a beginning enlargement of the costochondral articulations on the affected side, which are indicative of recurrent disease in the ribs. The others are all dead, in the majority of cases from intrathoracic metastasis.

Of the two cases that may be pronounced as cured, one was a woman, sixty-eight years of age, with a diffuse infiltration of the right breast, and with perceptibly large axillary and supraclavicular nodes. For three years she had been aware of the presence of this disease. In the second case likewise for more than three years the patient had been aware of the presence of a tumor in her breast; the whole gland had become manifestly involved in the disease, and had become converted into a large ulcerating tumor. In this case the axillary nodes were enlarged, but the supraclavicular nodes were not perceptible. The operative attempt to remove the disease was conducted in two stages,—first was done an excision of the breast and the axillary contents and the pectoral muscles; two weeks later, primary union of the first wounds having been secured, the clavicle was exposed by incision and double division of the bone made so as to leave its middle third loose, and attached merely by the subclavius muscle. This bone-muscle flap was then turned down so as to give complete access to the base of the neck, which was then carefully cleaned out. Some carcinomatous nodules were detected in the tissue removed from the neck; the osteoplastic flap was then replaced in its proper relations to the rest of the bone; rapid operative recovery from this second operation was secured. Four and a half years have now elapsed, and up to the present time she has remained perfectly well.

The experience of these years has emphasized most strongly to my consciousness the fact that nothing is more illusive than the apparent local extent of a carcinomatous process. In many instances the epithelial invasion which constitutes the essential element of the process has been for a long time slowly, insidiously, painlessly, and imperceptibly progressing, without producing manifest tumor, and without attracting the attention of the person affected, until by accident her atten-

tion is at last drawn to the alteration in the texture of the breast which has occurred; hence, little of importance can attach to the subjective symptoms which are elicitable in the history of these cases, and nothing is more unreliable than the statements of patients as to the length of time the disease has been present.

On the other hand, the size of the local growth and the rapidity with which its bulk has increased since its presence was detected, and the tendency to breaking down which it may exhibit when it comes to the surgeon's notice, is no positive index to the number and distance of the secondary outlying deposits which may have occurred along the outgoing lymphatic paths.

It is true that there are certain gross evidences of advanced carcinoma which, when they are present, are unmistakable as to their character and meaning, such as fixation of the gland to the subjacent muscle, palpable enlarged glands in the axilla and above the clavicle, and nodules in the circumjacent skin. Cases presenting such conditions fall without dispute into the category of cases of advanced carcinoma of the breast. Different from these are some growths which from the first exhibit a tendency to rapid local increase in size and early necrosis, without corresponding tendency to the development of metastases. They early attract attention and speedily come to extirpation, which, when done in the complete manner required by the pathological knowledge of the present day, is likely to result in permanent cure. While these latter acutely developing cases may also very properly be classed as cases of advanced carcinoma, the prognosis attending efforts at their removal is much more favorable than that which attaches to the cases of the more slowly diffused epithelial invasion. In the latter class of cases the skin over and adjacent to the breast may be apparently healthy and still harbor multiple points of metastatic deposit, as yet microscopic in size. Upon the whole, one is almost driven to the conclusion that clinically the surgeon never sees carcinoma of the breast in any other than an advanced state. Some cases when brought to his notice may certainly be farther advanced than others, but, without dispute,

every case when first brought to his attention has behind it a long period of development, and has connected with it every probability of many and distant metastases. Hence those surgeons alone are rational and correct who insist that in every case that comes to operation a far-reaching and wide-extending removal of overlying and adjacent tissue shall be made together with the removal of the affected breast itself. Every tissue related to the affected breast by propinquity or by connecting absorbent ducts rests under suspicion; the less the apparent advancement of the primary disease, the greater, of course, the probability of the successful result of the surgeon's efforts, and hence the greater the importance of the most radical and far-reaching extension of his removal of possibly affected tissue in presumably early cases. A wide area denuded of skin may readily be covered again by plastic flaps or by grafts; removal of both pectoral muscles entails surprisingly little ultimate disability, and most extensive wounds in the axilla and above the clavicle heal with certain promptness when made under the precautions required in the surgery of the present day. When the statistics of Billroth⁷ at Vienna were published in 1878, it appeared that of seventy-three women from whom he had removed the breast and axillary glands for cancer, twenty-seven had died as the result of the operation, more than one in every three operated upon! At the present day many lists of more than 100 similar consecutive cases have been published without a death. Among the fifty cases now reported by the writer there was but one operative death. Such a remarkable absence of mortality attending the extensive and prolonged dissections now employed in operations for cancer of the breast is due to three causes, all characteristic of the perfected methods of wound treatment of the present day, viz., the prevention of shock, careful haemostasis, and scrupulous antisepsis. Increasing appreciation of the pathological indications for radical operative measures and increasing perfection of operative technique have progressed with equal steps. Upon the combination of the two depends the great change for the better which has been effected in the operative possibilities in cases of carcinoma of the breast.

It ought to be unnecessary at the present day to call the attention of educated physicians to the high importance of immediate surgical interference in every case of even suspected carcinoma of the breast, unless there be circumstances attending the case which contraindicate any operation; and yet it is still the case that frequently patients are not presented to the surgeon until after they have been under the observation of physicians for many months, delay having been advised by the latter while they watched the progress of the growth. It is not rare that a patient who has discovered something wrong in her breast is told by her physician not to worry, to come back again in six months, or "in the fall," or to try some kind of treatment, and is thus led to postpone surgical relief until a period when the probability of its successful application is greatly lessened, if not absolutely destroyed. Nor is it the young and inexperienced or obscure practitioner that is always the greatest sinner in this respect. Of the fifty cases under consideration in the present report, thirty-seven had in this way postponed application for surgical relief after they had become aware of the existence of the disease for periods varying from six months to three years or more, the record being, for six months in twelve instances, one year in ten instances, two years in eight instances, and three years or more in seven instances! It cannot be too strongly emphasized that practically *every case of carcinoma of the breast, when it has reached that degree of development by which a palpable tumor is formed, is already in an advanced stage*, such an advanced stage that, as a rule, metastatic deposits have already begun to be formed, beginning in the near-by lymphatic paths, and that only by an immediate far-reaching removal of both the discernible disease and the adjacent tissue that may enclose metastatic points can even a moderate probability of permanent cure be assured. The differential diagnosis of neoplasms of the breast rarely presents any uncertainties to one who is familiar with them; the characteristics of the retention cysts, the adenomata and the inflammatory indurations, which constitute nearly all the non-malignant tumors of the breast, are usually well marked and readily

made out. If in any case any doubt exists, it is far wiser to give the benefit of the doubt to malignancy, and to at once proceed to its extirpation. Roger Williams analyzed 2422 consecutive cases of primary mammary neoplasms, and found of this number 1974 that were malignant, that is over 81 per cent.!

The operations required for the accomplishment of the wide-reaching removal of tissue called for by the known pathological conditions present in mammary cancer are laborious and time consuming, and for their best and most successful performance require a high degree of technical skill and a full equipment of assistants and of material. The multiplication of hospitals and the increasing number of able men with operative training and experience connected with them, however, place in most communities all the needed requisites for the more frequent performance of operations for cancer that comply with the demands of pathology.

Present experience warrants the statement that surgery can promise a very large proportion of absolute cures to cases of cancer of the breast, if its resources are employed as soon as the presence of the disease is determined, even though it be acknowledged that the disease is there already in an advanced stage.

It is not to be wondered at that in the past, with its records of high operative mortality and low ultimate immunity from recurrence, both patients and physicians have preferred to postpone efforts at extirpation until the burden of the local disease has become intolerable.

The influence of this attitude of a past generation still lingers, and to it is due much of the hesitancy to at once seek surgical relief which we have been deplored.

As the knowledge becomes more general as to what has been and can be done by surgery for the cure of cancer of the breast, less hesitancy will be displayed by its victims in at once availing themselves of the help which is offered, and the proportion of permanent cures effected will be increased.

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CYSTIC DEGENERATION OF THE MAMMA SHOWING TRANSFORMATION INTO SCIRRHOUS CARCINOMA.¹

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THE microscopic specimen that forms the basis of this communication was obtained during the study of a mamma removed from a woman of sixty-three years by Dr. W. W. Keen, through whose courtesy I am permitted to report the findings. The mamma contained a hard nodule 2.5 centimetres in diameter to one border of which was attached a long, thin band of tissue having the same general characteristics as the nodule itself. A number of the axillary lymph nodes were enlarged and hard. Histologic examination shows that portions of the mammary gland are involved by chronic interstitial mastitis, as evidenced by the presence of an increased amount of perilobular and intralobular connective tissue. This change, however, is not a conspicuous feature of the specimen. Many of the lobules are the seat of cystic degeneration, or involution, that has transformed them, in some instances, into a single cavity lined by one or more layers of low cuboidal or polyhedral epithelial cells. In other instances, several small cavities are found in a lobule, distinct evidence of beginning coalescence of some of them being present. Many of these cavities are partially filled by masses of granular débris containing epithelial cells exhibiting varying degrees of necrosis. The most important departure from the normal, shown in certain of the sections, is the presence within the stroma of irregularly outlined masses of polyhedral epithelial cells. These cells are

¹ Read before the Pathological Society of Philadelphia, May 28, 1903.

not limited by any membrana propria, but infiltrate the tissue in an irregular manner (Fig. 1). A significant fact is that, at several points in the wall of one of the large cavities previously described, the epithelial cells forming the lining have broken through the wall and are directly continuous with the

FIG. 1.

*Carcinoma arising in a mamma the seat of cystic disease.*

A. Necrotic detritus contained within a cyst.

B. Proliferating epithelium lining the cyst. At points this layer shows desquamation into the cyst cavity.

C. C. Two points where the epithelial lining of the cyst is continuous with the epithelium of the alveoli of adjacent carcinomatous tissue.

D. D. Epithelial nests characteristic of this type of carcinoma.

irregular masses of cells contained in the adjacent fibrous stroma. This cavity contains a large amount of granular débris and partially necrotic cells, and in other ways shows its identity in type with the cavities that are bounded by a membrana propria, and have been formed, or are in process of formation, from the acini of the gland. The enlarged axillary lymph

nodes contain large masses of epithelial cells similar to those in the mamma.

The diagnosis rendered in this case—cystic involution of the mamma undergoing transformation into a scirrhoue carcinoma—brings up a question that has been debated at length, many surgeons not believing that this change occurs. The study of a number of specimens of both cystic involution and carcinoma of the mamma has led the writer to believe that there is an intimate relationship between the two conditions. In other words, cystic involution may be, and perhaps often is, followed by carcinomatous change. It being impossible to prove this by the microscope in many instances, the present specimen, showing direct extension into the surrounding tissue of the epithelium lining a cyst, is thought to be worthy of exhibition.

Gross,¹ when considering the development of carcinoma, pictures much the same condition, but speaks only of the enlargement of acini or ducts, with proliferation and final extension of their epithelium, without mentioning previous cyst formation. That he did not consider cystic change to be a preliminary step in cancer formation is shown by the statement made in the chapter on cysts,² where he says, "In either event, the prognosis is favorable, as it is in all the cystic formations of the mamma."

Snow,³ under the title of "The Malignant Reversion of Mammary 'Cystic Fibroma,'" reports two cases,—one of transformation into carcinoma, the other into sarcoma. By cystic fibromas, Snow means the cyst formation that accompanies connective-tissue hyperplasia during the period of devolution or degeneration of the female breast after the approximate age of thirty-four years. This we take to be the origin of the cysts in the specimen under study. He states that the condition increases slowly for a term of years as a benign tumor, but surely in the end becomes associated with malignancy, either carcinoma or sarcoma, the former originating in the epithelium lining the cysts, the latter in the surrounding fibrous walls.

Sheild⁴ does not speak directly of the relation of cysts to carcinoma, but, after referring to the almost invariable presence of cysts in chronic mastitis, says that "The transition from chronic mastitis into cancer is considered so common as to have received notice from every writer on surgical pathology." For his own part he is inclined to the belief that many cases of cancer supposed to supervene upon chronic mastitis were cancer from the beginning, and that no previous chronic inflammation existed. Like Gross, he states that an early cancerous change is doubtless the spread of proliferating acinous epithelial cells into the connective tissue, but he does not mention cysts. He expresses serious doubt as to the generally accepted belief in the connection between cancer and chronic inflammation of the breast substance itself. The same writer in a later article⁵ advocates as treatment of cystic disease removal of the cysts or the injection method instead of amputation of the breast.

Johnson⁶ cites the case of a woman who had the left breast excised, because of cystic degeneration, in 1877. In 1882, the right breast was excised on account of the presence of a like condition. In 1889, a tumor which had been slowly growing for two years was removed from above the middle of the scar in the left side. This was found to be made up of two cysts containing papillary growths. The cysts were supposed to have developed from a fragment of mammary tissue left at the first operation. The chief interest in the case, according to Johnson, is found in the recurrence after ten years. This recurrence, especially of the type of cyst described, is to me suggestive of malignant disease.

Robinson⁷ reports a case of diffuse cystic degeneration of both breasts, the right being amputated in August, the left in November, 1894. The right showed chronic interstitial mastitis, was riddled with cysts, and contained evidence of carcinomatous change. The left was similar, with the exception that no malignant transformation was noted. Robinson believes that there is a causal relation between cyst formation

and malignant growth, and that cystic disease of the mamma should be subjected to radical treatment.

Bull⁸ begins the treatment of cysts of the breast by aspiration. Later operation in cases that refill, etc., is confined to excision of the cyst only. He states that there is little evidence that this condition degenerates into cancer. If it does, cancer certainly may be slow in its development. Cysts developing at or near the time of the menopause need not be interfered with.

Bryant,⁹ who at first argues against the causal relation of cystic disease and cancer, later drops this argument, and confines his discussion to the comparative merits of conservative and radical operations for cystic degeneration. His statements are somewhat conflicting. He says there is no reason to believe that women who have these cysts are more prone to cancer than those who do not have them, and that the condition is mostly amenable to local treatment without sacrifice of the breast. Later he states that "it seems probable, however, that all large cysts of the breast, if left untreated, will sooner or later become the seat of some proliferating intracystic growth which will be papillomatous, sarcomatous, or carcinomatous in its nature, according to the proclivity of the tissue to form, or of the individual to develop, either special variety." Bryant is an advocate of early operation for breast disease, for the following reasons: "Delay in removing the local disease, whether cystic or solid, is fraught with danger, whereas by early interference nothing but good can be achieved. In my belief, the presence of a simple cyst in the breast is no harbinger to future evil if it be treated and removed, although if left it may, without doubt, become a source of mischief; should a cyst containing intracystic growths be left untreated, it to a certainty will develop into a serious local affection." The treatment advised is the swabbing of simple cysts with carbolic acid or zinc solution and the removal of cysts which contain any intracystic growth. We take from Bryant's article that he admits the possibility of cystic disease becoming malignant, but his principal argument is nevertheless for conservative treatment of the condition.

Jonathan Hutchinson¹⁰ says: "It is admitted that these cysts start in the terminal acini or ducts, and are due to the constriction of the wall by the increasing fibrous tissue. The changes that the lining epithelium undergoes readily suggest a termination in cancer, but I believe with Bull and others that there is no proof of such transformation. The matter is of practical importance; many such breasts are excised with the fear that cancer will supervene; but there is an important argument against such excision, namely, that when one breast has become the seat of fibrous degeneration and cyst formation, the other gland will probably follow suit. Few women would submit to the successive removal of both breasts unless there was really good reason for believing that grave danger was thereby avoided. I would repeat that there is no evidence that carcinoma especially selects the breasts that are the seat of multiple cysts, and that, unless the patient is very anxious about the condition, it is better to leave them alone."

The question of treatment is beyond the province of this paper: the foregoing references to the literature of the subject being given because of their bearing on the pathological problem under consideration. It will be noted that exceedingly diverse opinions are held.

In only one way can these differences be reconciled and the true relation of the two conditions determined, and that is by the co-operation of the surgeon and pathologist, the former observing critically the clinical history of these cases, *whether operated on or not*, the latter making a careful and complete histological study of removed specimens. The question is not one for mere theorizing or the occasional exchange of conflicting opinions. Its settlement means much. Negative proof of the change means to a certain number of women the saving of one or both breasts; positive proof means to a larger number of women the saving of life. The cause of cancer is unknown, and the results of treatment are in too many instances disheartening. The only hope of lowered mortality at present offered by surgeons is that of earlier diagnosis and operation. Operation during the precancerous stage of certain affections known

at times to undergo malignant change, as leucoplacia linguæ and gastric ulcer, has its advocates. It is high time for the surgeon and pathologist to determine more definitely whether cystic degeneration of the breast is a precancerous manifestation. This is simply a question of earlier diagnosis, a problem to which every surgeon is committed.

In closing, the writer wishes again to emphasize his belief in the strong probability of malignant transformation occurring in cases of cystic degeneration of the female breast. The accompanying specimen, showing the transformation clearly, is offered as a contribution to the evidence in favor of the view indicated.

[NOTE.—Since this article was put in the hands of the printer, there has appeared a valuable contribution to the study of cystic disease of the mamma by Greenough and Hartwell.¹ They have examined a series of thirty cases of this condition, which they prefer to designate as chronic cystic mastitis, following the suggestion of Koenig. In three of the thirty specimens carcinoma was present as a secondary lesion, but was of the adenocarcinomatous type, no evidence of scirrhus being found. The writers conclude that "the danger of the transition of chronic cystic mastitis to adenocarcinoma is sufficient to make the removal of the entire gland advisable in all but very early and slight degrees of the affection." The operation advised is the subcutaneous resection of the entire gland without removal of the nipple.]

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SURGICAL TREATMENT OF CHOLELITHIASIS.

A REPORT OF THE OPERATIONS FOR CHOLELITHIASIS, IN THE SERVICE OF DR. A. G.
GERSTLER, AT MOUNT SINAI HOSPITAL, DURING THE FIVE YEARS,
1898-1902.

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In the entire surgical service of Mount Sinai Hospital during 1898 and 1899, and in the first surgical division during 1900, 1901, and 1902, we have operated upon sixty-one patients for cholelithiasis and its complications. Upon these sixty-one patients sixty-six operations were performed, with a mortality of eighteen, or 20 per cent. This high mortality needs a few words of explanation. It teaches in itself a most important lesson to those who never advise surgical interference until the patients have become exhausted by the pain of repeated attacks of colic, or septic from cholangeitis, or suppurative inflammation of the gall-bladder. The patients who come to the Mount Sinai Hospital are not of the class who select a quiescent period of their disease as a most fitting time for operation; they prefer, as a rule, to wait until threatening manifestations of intense sepsis, arising from cholangeitis, gangrene, or empyema of the gall-bladder, etc., compel them to seek the surgeon's aid. Thus of our sixty-one patients, nineteen had empyema of the gall-bladder, four, extensive gangrene, and six, obstructive jaundice at the time of their admission. Only twenty were admitted in or could be tided over into a quiescent period of the disease.

This delay in resorting to surgical interference until the exigencies of the case urgently demand it, accounts for the wretched physical condition in which our patients come to the hospital. They are mostly emaciated, nervous, and exhausted from their oft-repeated and prolonged attacks of pain, fever, and jaundice: their tissues are frequently in a condition of fatty and hyaline degeneration; their kidneys are functionally bad,

and their hearts often the seat of chronic interstitial changes. This accounts for the three deaths from collapse immediately or shortly after operation, even though the latter was not severe or unduly prolonged. Further, the resisting power of their tissues has become so bad that bacteria, which are present in the gall-bladder, find a favorable soil therein, after operation, for rapid increase and development; thus eight cases of rapid and fatal septicaemia, with no peritonitis, arising from septic foci in the gall-bladder or ducts occurred during these five years.

These facts show conclusively that if good results are to follow the surgical treatment of this disease, the patients must be operated upon early. In a previous communication the writer has stated the indications for the medical and surgical treatment to be as follows: (*Medical Record*, 1902. "Indications for medical and surgical treatment of cholelithiasis.")

Medical Treatment.—Cholecystitic pain or attacks of biliary colic, in either case unattended with fever.

Surgical Treatment.

1. Operations of choice, undertaken in the quiescent period; mortality, 2 to 3 per cent.
 - (a) Severe cholecystitic pain or oft-repeated, uncomplicated attacks of biliary colic, persisting in spite of medical treatment.
 - (b) After the first attack of acute cholecystitis attended with fever, pain, distention of the gall-bladder.
2. Compulsory operations, undertaken at any time of the day or night, often amidst unfavorable surroundings; high mortality.
 - (a) Foudroyant or intensely acute attacks of cholecystitis.
 - (b) Hydrops, empyema, gangrene, or perforation of the gall-bladder, cholæmia, abscess of the liver, diffuse peritonitis.

We do not advise surgical interference at the first attack of cholecystitic pain or biliary colic. We base this action upon

our knowledge of the pathogenesis of the lesions that follow upon cholelithiasis. Calculi themselves do not give rise to structural alterations in the gall-bladder; the pathological changes are dependent upon a secondary or mixed infection of this viscus. A primary infection of a diminished virulence, coupled with stasis of the bile, determines the formation of calculi within the gall-bladder or ducts; a secondary infection of varying intensity of virulence determines the acute or chronic inflammatory conditions that result in marked structural alterations and general septic intoxication. The calculi as foreign bodies in an irritable viscus may excite cholecystitic pain or biliary colic; the secondary infection gives rise to hydrops, empyema, gangrene, cholangitis, etc.

Medicinal, dietetic, and hygienic therapy usually succeed in relieving pain and colic in uncomplicated cases. Surgical interference will only be called for in this class of patients when the pain is continuous and severe, and is not benefited by general therapeutic measures.

The addition of a secondary infection in a calculous gall-bladder marks a strong indication for surgical interference. Our experience goes to show that sooner or later a secondary infection will give rise to such severe local lesions and general intoxication as to demand operation. If the onset of severe local and general disturbances is to be forestalled, recourse to operation must be made as soon as possible after the inception of a secondary infection of the gall-bladder.

As to operation in the acute attack or during a quiescent period. We naturally prefer to operate during a quiescent interval. At such a time the mortality is considerably less, and the search for stones in the gall-bladder and ducts can be made much more thoroughly and satisfactorily. It is in the operations performed during an acute seizure that calculi are overlooked, necessitating secondary operations for their removal.

The gall-bladder is not to be compared to the appendix vermiciformis in regard to the urgency of operative interference during a period of acute inflammation. The wall of the latter organ, poor in muscular and elastic fibres, can distend

very little to accommodate the products of inflammation that accumulate in it. With its orifice of exit closed, the rising tension of these confined products is very likely to result in perforation. The gall-bladder, on the other hand, is rich in elastic and muscular tissues; its walls readily stretch and its cavity distends to accommodate the inflammatory exudates; perforation is therefore comparatively rare. Whereas early operation is necessary in acute appendicitis in order to forestall perforation, such action is not often required in acute cholecystitis. We consider that immediate surgical interference is chiefly called for in the face of an advancing septic condition or in extreme distention of the gall-bladder; and that without these conditions it is usually safe to wait for a subsidence of the acute manifestations and operate during the interval. In our sixty-one patients only one, a recurrent empyema after cholecystostomy owing to obstruction of the choledochus, suffered with perforation of the gall-bladder. Forty others had to be operated in the acute period on account of septic manifestations; in these the mortality was 29 per cent. The other twenty were admitted in or could be tided over to the quiescent period; the mortality in these cases was 3 per cent. Here are included three deaths from continued hemorrhage.

THE LATE RESULTS AFTER GALL-STONE OPERATIONS.

The subsequent histories of most of the hospital ward patients cannot be ascertained; they have either changed their places of residence or do not respond to our letters of inquiry. However, as a rule, we have found that our patients return to the hospital for examination, if they suffer from a recurrence of the old malady.

Of those returning to the hospital in this way a number complained of dragging, dull pain in the right hypochondriac regions. The pain did not radiate; they stated that it was of an entirely different character from that with which they had previously suffered. These patients while under our observation never had an attack of biliary colic; no stones were passed

in their stools; they were not jaundiced. After a time the pain became very much less. We considered it was due to adhesions around the gall-bladder and ducts. During the past year we have operated upon two patients not included in this series, upon whom a cholecystostomy had been done in other hospitals. Both patients complained of severe pain in the right hypochondriac and epigastric regions, with marked tenderness over these areas. There had been no jaundice since the first operation; occasional attacks of fever. No stones had been passed since the first operation. The pain resembled that of biliary colic. Reoperation revealed only extensive intimate adhesions around the contracted gall-bladder, and the bile ducts; cholecystectomy and separation of adhesions have freed the patients of their pain.

In three cases postoperative herniae through the scar followed. In two of them, very stout patients, with flaccid abdominal walls, more than one operation had been done; at the last operation, both very large transverse and longitudinal incisions had to be made on account of the numerous and extensive adhesions between the gall-bladder and ducts and neighboring viscera. Radical operation was only once required, as the hernia and its attendant unpleasantness were easily controlled by a well-fitting abdominal belt.

Six of the patients in our series had to be reoperated to remove calculi in the cystic or common ducts that had not been taken out at the first operation. In four of these six cases the stones were impacted in the cystic duct; in two of the latter a previous cholecystostomy in two stages, and in two a cholecystostomy in one sitting had been done. The impacted calculi could be easily felt with a probe introduced through the fistula in the gall-bladder. Another patient in whom a cholecystostomy for empyema had been done returned to the hospital several months after the operation, with a diffuse purulent peritonitis, originating in a rupture of a recurrent empyema of the gall-bladder. The fistula had completely closed, but the common bile duct was obstructed by a large calculus which prevented the free discharge of gall-bladder secretions and bile

into the duodenum. Immediate laparotomy and drainage of the ruptured gall-bladder, and cleansing of the peritoneum, saved this patient's life, and at a third operation the common duct stone was removed, the patient making an uneventful convalescence.

In the sixth patient a cholecystostomy and cysticotomy had been done two years prior to her readmission to the hospital, when she presented all the indications of common duct obstruction. The gall-bladder fistula had healed. Exploration revealed an impacted stone in the choledochus.

In the above patients there can be no doubt that the calculi which were removed at the second operation were present in the ducts when the first one was performed.

In two cases in which cholecystostomy in two stages had been done, the calculi could be felt impacted in the cystic duct when the gall-bladder was first opened. Though their dislodgement was repeatedly attempted, the efforts were not successful. In the other two cases in which the operation was done in one sitting, evidence of the presence of obstruction in the cystic duct was afforded by the persistent patency of the gall-bladder fistula discharging mucus.

In the two cases in which at the secondary operations calculi were found in the common duct, the gall-bladder fistula had remained open for a long time. One patient remained well eight months after its closure, when a rupture of the gall-bladder occurred; in the other the fistula remained patent for seventeen months after the first operation, and from the time of its closure the patient suffered with repeated attacks of biliary colic, chills and fever. (It is to be noted in these last two cases that the gall-bladder closed some time after the primary operation; in one seventeen months and in the other about five months. Neither of these patients presented the symptoms of or gave a previous history of attacks of obstructive jaundice. The tardy closure of the gall-bladder fistula would indicate that the obstructing calculi were at first lodged in the cystic duct, and when they had passed into the common duct the gall-bladder fistula closed. Our experience would

seem to show that obstruction in the common duct, unless it be a very firm impaction, does not interfere with the closure of a gall-bladder fistula; whereas an obstruction in the cystic duct where firm impaction is the rule prevents such closure. Reference to this point will be made under cholecystostomy.)

To our knowledge only one of the other patients in this series presented evidences of a return of the symptoms due to the presence of calculi in the gall-bladder or ducts. Further, in all but this one of the remaining patients, no biliary fistula remained after the primary operation. We must conclude, therefore, that a reformation of calculi after they have been completely removed from the gall-bladder and bile passages must be a very rare occurrence. In this our experience coincides with that of Kehr.

After a close investigation into the subsequent histories of a large number of patients operated upon by him for cholelithiasis he was unable to find any instances in which a true reformation of calculi occurred. In all his cases that presented evidences of the presence of new formation of calculi in the ducts or gall-bladder done for cholelithiasis, he was able to prove that such calculi had been present at the time of the first operation, and had either been overlooked by the surgeon or, on account of the poor condition of the patient, or extensive adhesions around the ducts, their removal had been deemed inadvisable.

To avoid the repetition of this most disagreeable occurrence, viz., the overlooking of calculi in the bile ducts, we have of late followed in all our cases the following procedure. After opening the abdomen, the gall-bladder is exposed and examined. If it is very tense, its contents are withdrawn with an aspirating needle, the puncture opening being then closed by suture or clamp. This relief of tension within the gall-bladder renders palpation of this viscus and the ducts much more easy and satisfactory. The exploring hand is then introduced into the abdomen, along the under side of the gall-bladder, and carried along the under side of the cystic, hepatic, and common

ducts. Where these structures are surrounded by adhesions, the latter are divided until they are freely accessible. By rolling the ducts between the fingers, the smallest calculi are easily and readily located. In this way we ascertain at the very beginning of the operation the exact site of any calculi within the gall-bladder and ducts. The hepatic ducts beyond the portal fissure of the liver cannot be palpated, and must, in case calculi are suspected in them, be probed to ascertain the presence of the latter. To make our exploration of the gall-bladder more certain, for small calculi may even with this procedure escape detection, we always palpate the interior of the gall-bladder after it has been incised. Should the patient's condition, or the presence of numerous adhesions around the ducts, make it more advisable to postpone the removal of impacted stones in the cystic, hepatic, or common ducts to a subsequent time, we are in a position to know that a secondary operation will be necessary.

OPERATIONS UPON THE GALL-BLADDER AND DUCTS.

Abdominal Incision.—We usually employ a straight longitudinal incision through the fibres of the right rectus muscle, commencing at the costal arch and extending downward for three or four inches, preserving intact the seventh and eighth dorsal nerves that pass across this field. Where more room than is afforded by this incision is required, *c.g.*, in very obese subjects, this is obtained by making a second transverse incision at right angles to the first one and bisecting it. In very obese subjects, and in those in whom the liver occupies a high position, a transverse incision below the costal arch is made. This affords excellent access to a contracted, deeply-seated gall-bladder and ducts, and does away with the necessity of resecting the costal cartilages.

Postoperative herniæ do not very frequently follow even extensive incisions in this part of the abdominal wall. We have seen several small herniæ in very much relaxed and obese subjects. In those cases in whom the dorsal nerves have been divided there is a weakness of the entire upper portion of the

rectus muscle, which permits of a bulging and protrusion in this region; but even considerable degrees of this are easily controlled by a truss. The writer knows of only one case within the past five years that required operation for hernia arising after an operation for cholelithiasis.

The closure of the abdominal wound is made by layer suture of chromicized catgut. In very fat subjects the layer suture is reinforced by several through-and-through silk sutures. Such through-and-through sutures have very frequently in our experience given rise to extensive stitch-hole abscesses and even phlegmons. Though recognizing this great objection to their use, we do not dispense with them, because we have found nothing else to afford sufficient guarantee against a bursting open of the wound.

Cholecystostomy was performed thirty-eight times, with twenty-seven recoveries and eleven deaths. Of these twenty-seven were done during the acute period, and ten of them succumbed, two in collapse shortly after operation; the others from a more or less rapid but progressive septicaemia, no peritonitis. This would indicate that even a simple surgical procedure performed at a time when there is a virulent infection of the gall-bladder and ducts is attended with grave risks. It would seem as if the operative interference increased rather than diminished the intensity of the infection. The question naturally arises as to the advisability of performing cholecystostomy in the acute cases. We know that simple incision and drainage of purulent collections or gangrenous areas in other organs, e.g., the kidney or appendix, are not attended by results as good as those which the immediate removal of the affected organ accomplishes. The much inflamed, often gangrenous organ, whose vitality is further impaired by the necessary operative manipulations, is an excellent culture ground for the bacteria which are present, and their virulence is very apt to be much increased. Drainage of the gall-bladder is often very unsatisfactory on account of the numerous diverticula and sacculations that result from ulcerations and cicatrices within its cavity. Insufficient drainage and retention

of the products of bacterial life result in progressive septic intoxication, from which the patients finally succumb. During the past year we have in three acute cases performed cholecystectomy. They all made a smooth, uneventful recovery. Naturally all acute cases are not suitable for cholecystectomy; for the separation of numerous adhesions may spread the infection in the gall-bladder to the ducts and peritoneum, or it may be too formidable a procedure for a debilitated or already septic patient to endure. It does seem, however, as though primary cholecystectomy would give better results than simple evacuation and drainage.

Technique of Cholecystostomy.—After opening the abdomen, the gall-bladder is isolated and the surrounding adhesions divided. The contents of the gall-bladder are then evacuated by an aspirating syringe, and the puncture opening temporarily closed by suture or clamp. The gall-bladder and ducts are then carefully palpated, and the presence of any calculi noted. The gall-bladder is incised at its fundus, and the calculi removed. A large-sized drainage tube is put down to the bottom of its cavity and the edges of the opening inverted around the tube by several rows of purse-string sutures of catgut, as suggested by Kehr. The gall-bladder is then attached to the anterior parietal peritoneum, and the outer wound closed except at the site of emergence of the drainage tube. The latter is retained *in situ* by a rubber tube which fits snugly over it, and which is split into two lateral halves for the lower two-thirds of its extent; the lateral portions being affixed to the skin by adhesive plaster. The discharges are carried away to a bottle hanging at the side of the bed, thus preventing soiling of the outer dressings. Drainage is maintained until the bile appears sweet and clean, and the interior of the gall-bladder takes on a healthy appearance. Where the gall-bladder is deeply placed, and cannot be brought up to the abdominal wall, the interval between it and the parietes is packed with gauze, which is made to surround the drainage tube.

The operation is never done in two stages. The objection to this procedure lies in the fact that where stones are im-

pacted in the orifice of the cystic duct, they cannot always be dislodged, and secondary operations become necessary for their removal. In two of the four cases in which cholecystostomy was done in two stages, impacted stones were felt in the orifice of the cystic duct, but could not be dislodged through the fistula; secondary operations were required.

A persistent fistula discharging mucus was observed in seven cases. In four of these secondary operations revealed an impacted stone in the cysticus. In a fifth case, the persistence of a gall-bladder fistula discharging mucus convinced us of the existence of an obstruction in the cystic duct. Secondary operation was advised but declined by the patient. The fistula has persisted for five years, constantly discharging mucus and pus; recently a carcinoma of the gall-bladder developed. (In one other case in which cholecystostomy had been done for calculous empyema of the gall-bladder, a carcinoma of this viscus developed several months after the wound had completely healed. The new growth when the patient returned to the hospital was too extensive to permit of radical operation.)

With the old method of performing cholecystostomy, in which the edges of the incision into the gall-bladder were attached to the skin or fascia, fistulae were frequent, due to mucosa of the gall-bladder growing out and lining the drainage canal. Such fistulae had no dependence upon obstruction in the ducts, and could very easily be closed by plastic operation. The discharge from a fistula of this latter type is chiefly bile, in marked contrast to the mucus which issues from a fistula due to cystic obstruction. It is safe to close by plastic operation a fistula discharging bile, if we have previously convinced ourselves of the patency of the common duct, a fact that is readily ascertained by plugging the fistula with a tent and observing whether the bile is discharged into the intestine. It is unsurgical and unsafe to close a fistula discharging mucus or mucus and pus, for in these cases the cystic duct is obstructed, and no vent being afforded to the secretions of the gall-bladder, they accumulate in this viscus, and may cause its rupture, unless relieved by a reopening of the wound.

The persistence of a gall-bladder fistula discharging mucus seems to depend upon a complete closure of the cystic or common bile ducts, either by calculi, or strictures, or kinks, or external compression. As calculi in the choledochus are not apt to be firmly impacted therein, but float up and down according as it is distended or empty, they rarely cause a permanent complete closure of its lumen. The bile and secretions from the gall-bladder from time to time are afforded free discharge into the intestine. Calculi in the cysticus, on the other hand, are very likely, from the structure of the duct, to become firmly wedged at one point and completely obstruct the channel. Our experience would go to show that where the persistence of the fistula is due to the presence of calculi in the ducts, the site of such calculi is in the cysticus. In two of our cases in which a fistula persisted for five and seventeen months respectively, and then closed spontaneously, the calculi were found to occupy the common duct. It is more than probable, however, that these calculi originally, and during the time of the persistence of the fistula, were lodged in the cysticus, and that when they passed on into the choledochus, the fistulæ closed. This assumption is strengthened by the fact that the fistulæ did not discharge bile but bile-stained mucus, an indication of cysticus obstruction.

Cholecystectomy was performed six times, with five recoveries and one death. The Mayo operation (extirpation of the mucous membrane of the gall-bladder) was done three times, with no death. The Mayo operation is an excellent one in quiescent cases. It does not replace cholecystectomy in gangrenous or suppurative cholecystitis, nor in those cases in which the inflammatory process has extended beyond the lining mucosa of the gall-bladder. It is especially valuable in those cases in which, as the Mayos suggest, it is desired to remove the gall-bladder and drain the ducts at the same time. In an ordinary cholecystectomy the cystic duct is closed by ligature: if drainage is required, it is found very difficult to retain a tube in the cystic duct. In the Mayo operation the facilities for drainage are just as good as in an ordinary cholecystostomy,

as the muscular tissue of the gall-bladder affords an excellent pouch for collecting the secretions of the cystic and hepatic ducts, whence they are readily and easily conducted away. We would reserve the ordinary cholecystectomy for the acute cases of gangrenous or suppurative cholecystitis, employing the Mayo operation in the quiescent cases with deeply seated gall-bladders, in which, besides removing this viscus, we desire to establish drainage of the hepatic and cystic ducts.

Technique of Operation.—A peritoneal flap is formed on either side of the gall-bladder, which serves to cover the bed of this viscus after its removal. The organ is then freed from its attachment to the liver, likewise the cystic duct. The artery and duct are separately tied with catgut and the gall-bladder amputated distally to these ligatures. A small cigarette drain is passed down to the stump. Closure of the abdominal wound in layers.

OPERATIONS UPON THE DUCTS.

Cysticotomy was done four times, with three recoveries and one death. The duct was drained in all cases; no permanent fistula remained. In all the cases the cysticotomy was a secondary operation, cholecystostomy being done primarily. Had cholecystectomy been done primarily, these calculi could scarcely have been overlooked.

Combined cholecystostomy and cysticotomy were done in two cases; both succumbed,—one in collapse shortly after the operation, the other from a rapid septicæmia without peritonitis. It seems that operations upon the cystic duct when it is deeply seated and surrounded by adhesions are not well borne. The mobilization of the duct sufficient to enable the operator to incise it is deeply shocking; furthermore, drainage is unsatisfactory, for the tube is likely to be displaced. In acute cases it would seem to be much better to perform a cholecystectomy and then split up the entire length of the cystic duct, and in the quiescent cases to incise the gall-bladder and cysticus throughout their entire extent, remove the calculi, and extirpate the mucosa of the gall-bladder, leaving the muscular tissue of the latter to serve as an aid to drainage.

Choledochotomy was done four times; all recovered; in one of the cases a previous cholecystostomy and in another a primary cysticotomy had been done. Combined choledochotomy and Mayo's operation were done twice; both recovered. Combined cholecystostomy and choledochotomy were done four times; two recovered and two died from continued capillary haemorrhage. Combined cholecystectomy and choledochotomy were done once, death being due to continued haemorrhage. Simple or combined choledochotomy was therefore done eleven times, with three deaths from continued capillary haemorrhage.

HÆMORRHAGE IN JAUNDICED PATIENTS.

Persistent and uncontrollable capillary haemorrhage has been and continues to be the most lamentable sequela to operations in deeply jaundiced subjects. It is especially apt to follow when the cause of the jaundice lies in a malignant obstruction of the bile ducts. Its cause has been put down to retarded coagulation of the blood. It has been urged to improve this by the internal administration of calcium chloride. Following this suggestion, we have systematically administered the calcium salt in small and in large doses, and have in all cases given it at least five days before operation. Yet during the past year two of our cases succumbed from persistent, uncontrollable capillary haemorrhage.

It seems to us that the cause of this uncontrollable capillary oozing lies not so much in the retarded coagulation of the blood, as in a fatty degeneration of the walls of the arterioles, which interferes with their contraction and retraction. Physiology teaches that the cessation of haemorrhage is due to two causes,—chiefly and primarily the contraction and retraction of the arterioles into their sheaths, and secondarily to the clotting of the blood. It is hardly possible that a retardation in the coagulating time of the blood should be responsible for the persistent oozing that occurs in these cases. Were this alone the cause, we would expect that the rapid induction of coagulation by the cautery or styptics, etc., would arrest the hæmor-

rhage. This is not the case; the bleeding goes on, even though we resort to every known therapeutic measure. On the other hand, it is well known that chronic jaundice causes a marked atrophy of all muscular tissue. Such atrophy of the muscular tunic of the blood-vessels interferes materially with their contracting power. The arteriole when divided does not contract and retract within its sheath; its orifice remains patent, and no clot can remain firm over it. The arterial pressure behind the clot forces it off as soon as it forms. To support the pressure, there is need not only of a clot, but of a contracted and retracted arteriole.

If this explanation of the causation of continued haemorrhage is true, we would expect that the longer the duration of the jaundice the greater would be the tendency to bleeding, for the degeneration should be more marked. This is exactly so, as every surgeon has experienced. Further, we would expect that, as cancerous cachexia, chronic sepsis, and other debilitating influences give rise to a fatty or waxy degeneration of the tissues, patients suffering from these associated diseases would be more apt to bleed than those who suffer from chronic jaundice alone. This is also substantiated by experience; they form the greatest percentage of patients in whom this fatal complication occurs. If we accept this degeneration of the blood-vessels as the cause of this uncontrollable bleeding, we can readily understand why all therapy, including the calcium salt, fails to prevent or check the haemorrhage, and we will have to expect that from time to time cases will be encountered in which death will follow from the persistent capillary oozing.

Technique of Choledochotomy.—A firm, hard cushion is placed across the lower dorsal region; the common duct is thus brought nearer to the anterior abdominal wall, and the manipulations are rendered much easier. The duct is exposed and rolled between the fingers until it alone is grasped, the portal vein and hepatic artery being displaced to either side. The calculus is steadied between the index and middle fingers of the left hand, and the wall of the duct incised over it. The stone is removed by forceps or scoop. In only two cases was

the duct sutured; no leakage of bile followed. In all the others the duct was drained. Should the stone occupy the retro-duodenal part of the duct, it is displaced upward to the free portion of the latter, as it lies in the gastrohepatic omentum. We have not had occasion to practise transduodenal choledochotomy.

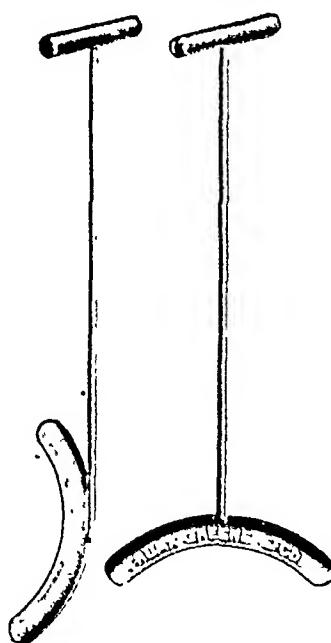
Thanks are due to Dr. Bauman, of the house staff, for valuable aid in collecting the cases.

A PROSTATIC TRACTOR FOR PERINEAL PROSTATECTOMY.

BY G. FRANK LYDSTON, M.D.,
OF CHICAGO,

Professor of Surgical Diseases of the Genito-Urinary Organs, University of Illinois.

IN many cases of prostatectomy the ordinary sound serves to depress the prostate sufficiently to permit of the enucleation of adventitious growths, if the operator be familiar with the operative technique. In quite a proportion of cases, however,



Lydston prostatic tractor.

a tractor of some kind is necessary. I submit an instrument of my own device which seems to answer the indications admirably. The instrument when closed is passed into the bladder *via* an opening in the membranous urethra—which is exposed thoroughly by the Y-incision—precisely as a urethral sound is introduced. It is opened in the cavity of the bladder by the finger through the perineal wound. During the operation, an assistant makes such traction upon the handle of the

instrument as is necessary to bring the prostatic overgrowths within reach of the finger or forceps. When the operation is completed, the finger is passed into the bladder beside the slim wire shank of the instrument, and the latter closed and withdrawn.

In regard to prostatic tractors, it will be remembered that cases occur in which no amount of traction within the limits of safety will bring the prostate within reach. In such cases suprapubic prostatectomy or the combined operation is necessary.

A CASE OF ASCITES DUE TO LIVER CIRRHOSIS TREATED BY OPERATION.

BY RUTHERFORD MORISON, M.B., F.R.C.S.,
OF NEWCASTLE-UPON-TYNE,
Surgeon to the Royal Infirmary.

R. P., aged fifty-two years, was admitted to the Royal Infirmary, Newcastle-upon-Tyne, on 27th February, 1899. Six months before he had begun to have occasional swelling of the abdomen, attended by a dull aching pain and swelling of the legs and feet. Three and a half months later the abdominal swelling and pain became permanent and the swelling steadily increased. He had felt sick at times, but had never vomited. His urine had been scanty, high-colored, and thick on cooling. The bowels were constipated, but no blood had been noticed in the motions.

Previous History.—He had had a rupture in the left groin for many years, which had grown more troublesome lately. Two and a half years ago he was treated in the Newcastle-on-Tyne Infirmary for delirium tremens. Previous to the attack he had been a heavy drinker; since then he had abstained entirely from alcoholic drinks. He had never had syphilis or other serious illness.

From the time of his admission till the operation in August he was under the care of Dr. George Murray, to whom I am indebted for the following note. "The main line of treatment has been as follows: Limitation of fluids taken, regular administration of mist. purg. alb., and tapping of the abdomen on left side by means of Southey's trocar. Girth at umbilicus before tapping, 36 inches.

Date of Tapping.	Quantity removed. Fluidounces	Girth of Umbilicus after Tapping. Inches.
March 11.....	285	31
March 25.....	197	34
April 1.....	122	34½
April 8.....	317	32
April 20.....	114	35
		361

Date of Tapping.	Quantity removed. Fluidounces.	Girth of Umbilicus after Tapping. Inches.
April 30.....	97	34½
May 10.....	169	
May 20.....	176	
May 30.....	186	
June 11.....	167	
June 21.....	204	
July 2.....	212	
July 22.....	330	
August 9.....	354	
Total.....	2930 fluidounces, 18 gallons, 2½ pints.	

The case was discharged from the medical wards on August 17, 1899."

On admission to the surgical ward, his condition was described as follows: He was a thin man with sallow complexion, sunken cheeks, and yellow-tinted conjunctiva. His tongue was clean and moist, appetite fairly good, arteries slightly atheromatous; pulse 92, and temperature normal. No jaundice or other disease discovered beyond what follows. His abdomen was much distended, and the physical signs were those of a large collection of free fluid. The left side of the scrotum was swollen from fluid distending a hernial sac.

Dilated subcutaneous veins were visible, starting from the neighborhood of the umbilicus, and terminating in one large trunk on either side, which ran up over the chest into the axilla. The direction of the blood current in them was ascertained to be from below upward. Percussion showed an increased splenic and diminished liver-dulness. There was some oedema of the feet and legs extending as far as the middle of the calf.

On August 29, 1899, the patient was operated upon, under chloroform. An incision about four inches long opened the abdomen between the ensiform cartilage and the umbilicus (Fig. 1). The cut subperitoneal fat was vascular, and bled freely. A large amount of clear straw-colored fluid escaped as soon as the peritoneum was divided. A second opening was next made between the umbilicus and pubis, large enough to admit a half-inch diameter glass drainage tube, which passed through it into the pelvis. Some adhesion was present between the liver and the omentum and between the omentum and the abdominal wall. The liver was firm, finely granular on the surface, and of about



FIG. 1.—R. P., before operation. Shows the distention of the abdomen, with some venous trunks coursing up towards the axilla.

normal size. The spleen was hard and enlarged to at least double its normal size. The abdominal cavity was dried with sponges, special care being taken to rub the surface of the visceral peritoneum opposed to them. The omentum was fixed across the anterior abdominal wall by catgut sutures.

The upper incision was entirely closed by catgut sutures. The lower was kept open for a drainage tube, through which the fluid was pumped out of the pelvis. Over the dressings, broad, long strips of adhesive plaster were applied transversely from the chest above to the drainage tube opening below. This was for the purpose of keeping the upper part of the abdominal cavity empty of fluid and the parietal closely applied to the visceral peritoneum.

Two nurses with a reliable knowledge of antiseptic wound treatment were told off to look after the tube and keep any fluid from collecting in the pelvis or from escaping on to the dressings.

The operation was well borne and his recovery straightforward. The following shows the amount of fluid removed daily from the tube:

	1899.		1899.
August	29, 5 xxiii.		September 16, 5 xvi, 3 v.
"	30, 5 xii.		" 17, 5 xxi, 3 vi.
"	31, 5 xix.		" 18, 5 xiv, 3 vi.
September	1, 5 xvii.		" 19, 5 xvi, 3 i.
"	2, 5 xix.		" 20, 5 xiv, 3 i.
"	3, 5 xiii.		" 21, 5 xiv, 3 iv.
"	4, 5 viii.		" 22, 5 xvi, 3 iii.
"	5, 5 xvi.		" 23, 5 xiv, 3 iii.
"	6, 5 xiv.		" 24, 5 xvii, 3 x.
"	7, 5 xi.		" 25, 5 xvi, 3 vi.
"	8, 5 xiii.		" 26, 5 xv, 3 vi.
"	9, 5 xiv.		" 27, 5 xiii, 3 vi.
"	10, 5 xiii.		" 28, 5 xi, 3 v.
"	11, 5 xiii.		" 29, 5 xix, 3 iv.
"	12, 5 xi.		" 30, 5 xvi, 3 iii.
"	13, 5 xiv.	October	1, 5 xix, 3 v.
"	14, 5 xvi.		" 2, 5 x, 3 i.
"	15, 5 xv.		" 3, 5 xii, 3 vii.
			" 4, 5 xii.

October 9. For the last few days very little fluid had escaped from the tube. There was some œdema of the scrotum and subcutaneous tissues of the back.

October 10. The tube was removed. There was no fluid escaping from it.

October 16. Patient very well; appetite good; quantity of urine, 63 ounces; the abdomen was a little distended; it measured 24 inches round the umbilicus. There was dulness on percussion in left flank reaching as far forward as the anterior axillary line. This disappeared on turning over. The veins of the abdominal wall were not so prominent, and there was much less œdema of the scrotum and back.

Three weeks after the patient left the infirmary (17th December, 1899), he returned with signs of a large fluid collection in the abdomen; 230 ounces were removed by tapping. He had passed only about 18 ounces of concentrated urine daily.

January 3, 1900. Better; signs of very little fluid in belly.

From this date there was no further accumulation of fluid, and at the present time (February, 1903) "he is very well; never looked better; is fat and strong, and has a good appetite. There are no signs of fluid in the abdomen. The veins in the abdominal wall are very large. He complains of some dragging pain in the abdomen; the liver can be felt adherent to the abdominal wall." (Note by Mr. G. Grey Turner, Surgical Registrar.)

That the ascites due to liver cirrhosis can be cured by operation is no longer in doubt. Abundant evidence has appeared in recent medical journals to this effect, but not all authorities are agreed as to how this has been brought about. The majority of writers support the view that the establishment of an efficient anastomotic circulation is a sufficiently satisfactory explanation, but all are not yet convinced. I have already recorded (*Lancet*, May 27, 1899) the post-mortem findings in the case of a woman who died two years after the operation which had cured her ascites, and they offer the strongest support to this belief. Examination of the superficial veins in the abdominal wall of the present case is of great interest in this connection. The photographs show so clearly the points of importance that no detailed description is necessary. On the left side the presence of a hernia necessitated the use of a truss (Fig. 2), pressure of which on the

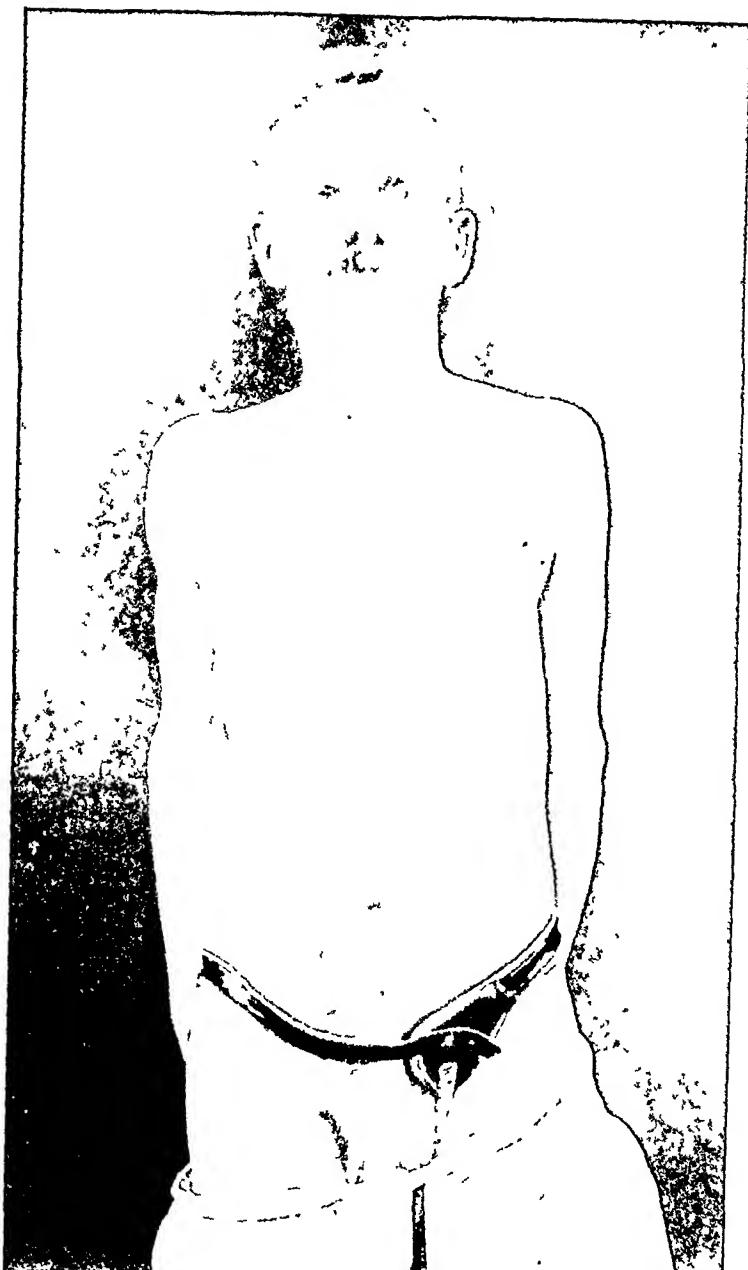


FIG. 2—R P three and one half years after operation. Shows the enlargement of the epigastric vein on the right side. The wearing of a truss has prevented the enlargement of the corresponding vein on the left side.



FIG. 3—R. P. three and one-half years after operation. Shows the enlargement of the epigastric vein on the right side. The line of the incision above the umbilicus and the site of the drainage tube below it are also seen.

superficial epigastric vein has prevented its enlargement on that side. On the right side the superficial epigastric vein has developed into a large trunk, through which a vigorous circulation is carried on between the groin below and the axilla above (Fig. 3), the blood current running in the upward direction.

Other factors besides mechanical obstruction of the portal vein doubtless aid the development or retard the arrest of ascites due to cirrhosis; but my cases prove at least that the establishment of an artificial accessory circulation can cure it.

Until a paper by Dr. Charles H. Frazier, to whom I am also indebted for reference to the originals, on the operative treatment of hepatic cirrhosis appeared in the *American Journal of Medical Sciences* for December, 1900, I was unaware that any one had a prior claim to having suggested such a procedure.

I can now only claim for Dr. Drummond and myself that our views and treatment were entirely independent and original. His belief was that in certain cases of cirrhosis, ascites might be prevented by an increased circulation through enlargement of normal channels between the portal and systemic veins; mine, that if his explanation was correct, it might be possible to cure such ascites by the formation of a new and accessory circulation, for which purpose I devised the operation described.

With the important exception that, so far as I can learn, the priority of suggestion belongs to Professor Talma, the following account as given in Dr. Frazier's paper previously alluded to is correct.

"*Historical.*—Though the operation for the relief of ascites due to cirrhosis of the liver was suggested some years ago, it is only recently that it seems to have attracted the attention it deserves, and to Mr. Rutherford Morison belongs the credit of having brought the first case to a successful issue. The operation had been performed on several occasions before, however. In 1889, Von der Meule performed a similar operation, but his patient died almost immediately of shock; Schelky followed in 1891, and his case also terminated fatally, death being due to

peritonitis; finally, in 1892, Lens, of Holland, reported a case in which he sutured the edge of the omentum to the wound, but without affording the patient any relief; the patient died six months later, during which time it was necessary on four occasions to resort to paracentesis.

"Morison's first case was equally unsuccessful, but in his second he obtained results which substantiated the claims made on behalf of this rather novel procedure. Whereas prior to the operation his patient had to be tapped frequently, she lived for two years without any reaccumulation of fluid, death having been due to an operation for ventral hernia which had developed at the site of the cicatrix."

GANGRENE OF COLON AND ILEUM AFTER OPERATION FOR APPENDICITIS.¹

BY NATHANIEL PENDLETON DANDRIDGE,

OF CINCINNATI,

Professor of Surgery in the Miami Medical College.

THE case which I have to report is one in which extensive gangrene of the ileum and caecum resulting in an artificial anus occurred after an operation for appendicitis. After an unsuccessful attempt at relief by a lateral anastomosis between the small intestine and transverse colon, an end-to-end anastomosis with a Murphy button was partially successful, leaving, however, a faecal fistula. This was finally closed after two more operations.

March 25, 1901, I was asked by Dr. Joseph Eichberg to see L. B., aged twenty-six years, who was suffering from an attack of appendicitis. Within two years he had had eight attacks of varying severity; none, however, requiring rest in bed for more than a day or two. The present attack had commenced some ten days before; the symptoms, mild in character, had been persistent, but at the time first seen had come to a standstill, and, indeed, seemed to be on the decline. There was a marked tumor in the right side in the region of the appendix. The outline towards the median side could be well defined; above, below, and to the outer side the limits were not so well marked. The tumor was not very sensitive to pressure, though rigidity of the abdominal wall was present. The temperature was 101.4° F., and the pulse but slightly above normal. As the symptoms seemed to indicate improvement, it was decided to wait until all fever had subsided, and then operate. After a few days, however, fever and pulse both increased, and it was decided to operate at once. This was done March 31. The incision was made at the outer edge of the rectus muscle. Opening the cavity, the appendix could not be found. We came, however, on the mass

¹ Read before the American Surgical Association, May 13, 1903.

which gave rise to the tumor found at the first examination, on the inner side of the colon and above the ileocæcal valve. This was beneath the peritoneum, bound down to the psoas muscle and overlapping its inner edge. It was thought to be a mass of exudation about the appendix, and I at once proceeded to enucleate it with the finger. When partly separated, a vessel of some size was seen to penetrate and pass through it, so that the pulsation could be felt beyond. It was necessary, therefore, to ligate the vessel before removal was completed. The parts removed proved to be some enlarged glands about the size of a hen's egg. They appeared to belong to the iliac chain of lymphatics, and were presumed to be tuberculous. This view, however, was not sustained by the subsequent microscopic examination, and they were doubtless mesenteric glands. The appendix was subsequently found behind the cæcum. It was three inches in length, reddened, thickened, and club shape, the tip being enlarged. There were no adhesions. No pus was found.

The cavity made by the removal of the glands was then mopped out, and, as no pus had been seen and the peritoneum everywhere appeared normal, the wound was sewed up without drainage. The operation was made under ether. On the morning of the third day a dose of castor oil was given, and this was followed later by a salt and glycerin enema. Vomiting occurred from time to time during the day and bowels moved at 10 P.M. Temperature had once reached 101° F. During the next few days there were some vomiting and a good deal of nausea. The bowels moved naturally and freely. The temperature became normal, and the pulse ranged from 64 to 70. On the morning of the seventh day some of the stitches were removed, and the wound found healed by first intention throughout. The nausea had disappeared, and the only discomfort complained of was a dragging sensation in the right side when he turned over on the left. On the morning of the eighth day the condition was so favorable that I announced that my daily visit would be discontinued. That evening he complained of severe pain in right side, and in the middle of the night the dressings were found saturated with a thin faecal discharge from wound. When seen the next morning the fresh dressings were again saturated, and gas and thin faecal fluid were found escaping from the upper extremity of the incision, the rest appeared firmly united. All of the remaining

stitches were removed, the lips of the upper part of the wound for an inch were separated by forceps, and then at once presented a small bit of sloughing membrane. By night the wound had opened throughout its entire extent, and a portion of gangrenous bowel, apparently the colon and some two or three inches in extent, was hanging out. The temperature rose to 101.4° F., but soon reached normal again; the pulse never went above 88.

The next day the projecting mass of sloughing intestine was sundered with scissors; it came from the colon, but did not involve the entire circumference. The pouch removed contained light brown faeces. The next day a further portion of sloughing intestine had escaped from the wound, and was likewise removed; and a day or two afterwards a piece of small intestine nine inches long was washed out of the wound. During this time fluid or mushy faeces was continually escaping from the side, the wound having gaped wide open. There was persistent nausea, and koumiss was the only nourishment retained. The temperature was about normal, the pulse was above 90. The urine was voided in full quantity,—usually voluntarily; but at times the catheter was used. The opening in the bowel at this time could not be seen. From the pieces removed, it was estimated that fifteen inches of small intestine and caecum had sloughed away. A rise in temperature after a few days occurred, and was followed by the escape of pus from the upper and outer side of the wound; the faeces came from the lower part. From time to time a rise of temperature occurred with the escape of pus. This continued for some days, when a drainage tube was inserted into a small abscess cavity. Drainage being secured, the discharge of pus ceased, and with it the temperature. On April 14 an enema was given and some scybalaous faeces removed. Subsequent enemas partly escaped through the wound and were partly returned, but no faecal discharge secured. The wound soon took on a healthy action and filled up and contracted, and after a time the opening in the small intestine from where the faeces escaped could be identified, and the further contraction of the wound brought it nearer the surface. The character of the discharge would vary, dependent upon the condition of the digestion; sometimes a thin, acrid discharge would excoriate the surrounding skin, then there would be simple mushy brown stools, and occasionally curds of milk. For days milk was the principal diet, and for a time

there was a progressive emaciation, which, however, passed away on a more liberal diet. Bismuth, magnesia, and some form of opium had to be resorted to to restrain the action when the discharge became thin. The discharge of faeces would occur without the patient's knowledge, and the dressings were changed about four to six times daily.

Thus things continued,—the wound granulating and contracting; there was evident improvement in nutrition; a varied diet was allowed, and the character of the discharge indicated a satisfactory digestion.

As the condition seemed favorable, it was determined to try and relieve the artificial anus by operation. After full consideration, it was determined to establish a connection by lateral anastomosis between the small intestine and sigmoid flexure in the hopes that the greater part of the faeces would be diverted, and that subsequently the artificial anus could be dealt with more safely. The patient was prepared, and the operation was made May 19, forty-nine days after the first.

The old wound was first flushed out, and then sewed up tight so as to prevent any contamination by escaping faeces. An incision was then made half an inch to the left of the median line and the cavity opened through the rectus muscle. The right side of the abdomen was found well walled off, the rest free of adhesion. The small intestine leading down to the adherent part was somewhat thickened and reddened. It was found difficult to draw up the sigmoid flexure sufficiently on account of a short mesentery, and it was decided therefore to make the anastomosis to the transverse colon. This was drawn down, and a point selected as far away from the opening in the ascending colon as possible. The point selected for the anastomosis in the small intestine was eighteen inches from the adhesion in the right iliac fossa. The anastomosis was made with the O'Hara forceps and the approximation readily accomplished. The loop of intestine leading to the anastomosis was then brought together by some stitches in order to secure sharp angulation at the opening as an extra precaution against the passage of the faecal current beyond the opening in the colon. The abdominal wound was closed without drainage and the original wound reopened.

It was hoped that the lateral anastomosis would carry off the greater part of the faecal current, if not all; the sequel shows

that this hope was not well founded. The day following there was some greenish vomiting, and on changing the dressing over the old wound some mucus and a little pus escaped, and the next day some thin faeces. On the fourth day an enema was given and retained; later the dressing in the side was found saturated with water stained with faeces. On the fifth day a glycerin suppository was inserted at 7 A.M., and again at 6 P.M.; the next day gas was expelled from rectum, and the bowels moved, the motion consisting of small masses of faecal matter and mucus, and the abdominal pain which had been complained of ceased. The temperature once reached 100° F., but most of the time was normal. Enemas brought away small amounts of faeces, the discharge from the artificial anus being nearly as free as ever. May 29 the stitches were removed from the median incision; the next day some foul pus escaped from a stitch opening. This continued to discharge for some days with an increase of temperature. The original wound continued to contract. The faecal discharges were from four to six daily. June 7 there was a motion by rectum, and for several days there were well-formed stools by the natural channel. These, however, soon ceased. For some weeks, however, enema would bring away some faecal matter, but were finally returned unchanged. The lateral anastomosis was therefore a complete failure so far as relieving the artificial anus was concerned. Matters remained unchanged during the summer. The general health improved. Nutrition was good and a number of pounds in weight gained. Sometime in August the patient passed a small phosphatic calculus, and some pus-cells were found in the urine. Subsequently, several other masses were voided. From time to time pain and swelling in the left side with fever left no doubt of the existence of a calculous pyelitis.

On returning from my summer vacation, it was determined to attempt the relief of the artificial anus by uniting the ileum and colon in an end-to-end anastomosis with a Murphy button. This was done October 8,—189 days after the first operation.

The patient had gained a number of pounds of flesh during the summer; looked well; ate freely of whatever he desired, and the character of the stools indicated that it was well digested. The incision from the first operation had contracted to two inches. The opening of the small intestine from which the faeces discharged was raised above the level of the skin and the mucous

membrane everted. A vermicular movement of the mucous membrane always preceded the faecal escape. There were firm adhesions around the small intestine on all sides, except at the upper and outer end of the wound, from which oil injected by the rectum had escaped a few days before, showing that the opening led to the colon.

Chloroform was administered, the patient being a long time in going under. The finger was introduced into the artificial anus, and penetrated about two and one-half inches, when it was blocked apparently by the intestine making a sharp bend. A Nélaton catheter stopped at the same point. The opening was first closed by stitches to prevent the escape of faeces during the operation. The wound was now circumscribed by an incision in normal skin, and the abdomen was opened through the fibres of the rectus muscle. The transverse colon first came into view, and an attempt was made to inspect the site of the lateral anastomosis. This was unsuccessful owing to omental adhesions. The ascending colon was identified. The open end was fixed quite deeply, and freed with a good deal of trouble and brought to the surface. It was found necessary to freely trim the ragged edges before the button could be adjusted, which was done with difficulty, owing to the varying thickness of the tissues. The small intestine was now freed from the adhesion about it. The bowel was thickened, and the peritoneal coat had disappeared from the adhesions. The everted mucous membrane was removed, and the button was adjusted with difficulty owing to the thickness of the tissue. The two sections were brought together without tension and the line of union fortified by some stitches. Strips of iodoform gauze were placed on either side of the bowel and the ends of the wound closed except about two inches.

The operation lasted two hours, and at the end a normal salt solution injection was given. Recovery from the anaesthetic was fairly prompt, but was followed by a good deal of thirst and vomiting. On the third day the gauze was removed, and the same evening a grain of calomel was given, followed the next day by one-tenth grain hourly. Gas began passing by the rectum on the second day, and on the evening of the fifth day there were two free stools at an interval of an hour and a half,—dark colored, pasty, and offensive. On the morning of the sixth some faecal fluid stained the dressings and a fistula was established. Regu-

lar discharges, however, were secured daily by glycerin suppositories, the amount escaping from the fistula varying with the condition of the bowels, averaging probably one-fifth of that by the rectum. The wound rapidly cicatrized until the opening was only large enough for a large sized probe. Later, two attempts were made to close the fistula by operation, the only result being an increase in the amount of discharge for a time. In the mean time there was a serious attack of pyelitis. The temperature varied from 101° to 102° F. A pronounced swelling with pain on pressure occurred over the left kidney, while the urine was found free from pus. Then suddenly occurred a free discharge of pus with the urine and a sudden cessation of all the symptoms, fever and swelling both disappearing. Since then, however, there has always been a trace of pus in the urine. Various colostomy pads were tried in January, 1902, and a final closure of the opening secured by the pressure of a rubber sponge held in place by an elastic bandage around the waist. It is now over fifteen months since there has been any discharge, and the man has been for some time engaged in active business.

In reviewing this case, it is evident that the glands removed were mesenteric, and that a branch of the ileocæcal artery was tied. It seems remarkable that in the presence of advancing gangrene the bowels should have continued to move and the general health maintained,—pulse and temperature remaining normal; and still more remarkable that the gangrenous bowel should have broken through a closed wound and not infected the general peritoneal cavity. The lateral anastomosis proved a complete failure in relieving the artificial anus. The local conditions at that time were such that an end-to-end anastomosis between the artificial anus and the ascending colon seemed impossible without contamination of the peritoneum, and the union of small intestine and transverse colon seemed to offer a good chance for amelioration and marked diminution of discharge from side, if not complete success, and with comparatively little danger. The change in the local condition effected by the contraction of the wound was most marked. The opening in the small intestine from

which the faeces escaped was brought up beyond the level of the skin, so that it could be easily closed by stitches as a preliminary step in the operation. The ends of the bowel did not, it must be confessed, appear in good condition for the use of the button; in the small intestine the peritoneal coat had been completely destroyed by granulations, and over the colon partly so. This condition possibly explained the resulting fistula; owing to the uneven thickening of the tissues, the two sections of the button were brought together with great difficulty.

At another time I should not attempt the lateral anastomosis, but wait until the process of repair had placed the local condition in a state favorable for the end-to-end operation.

The pressure from an India rubber sponge effected the final closure after failure by the colostomy pad. The Murphy button was never heard from.

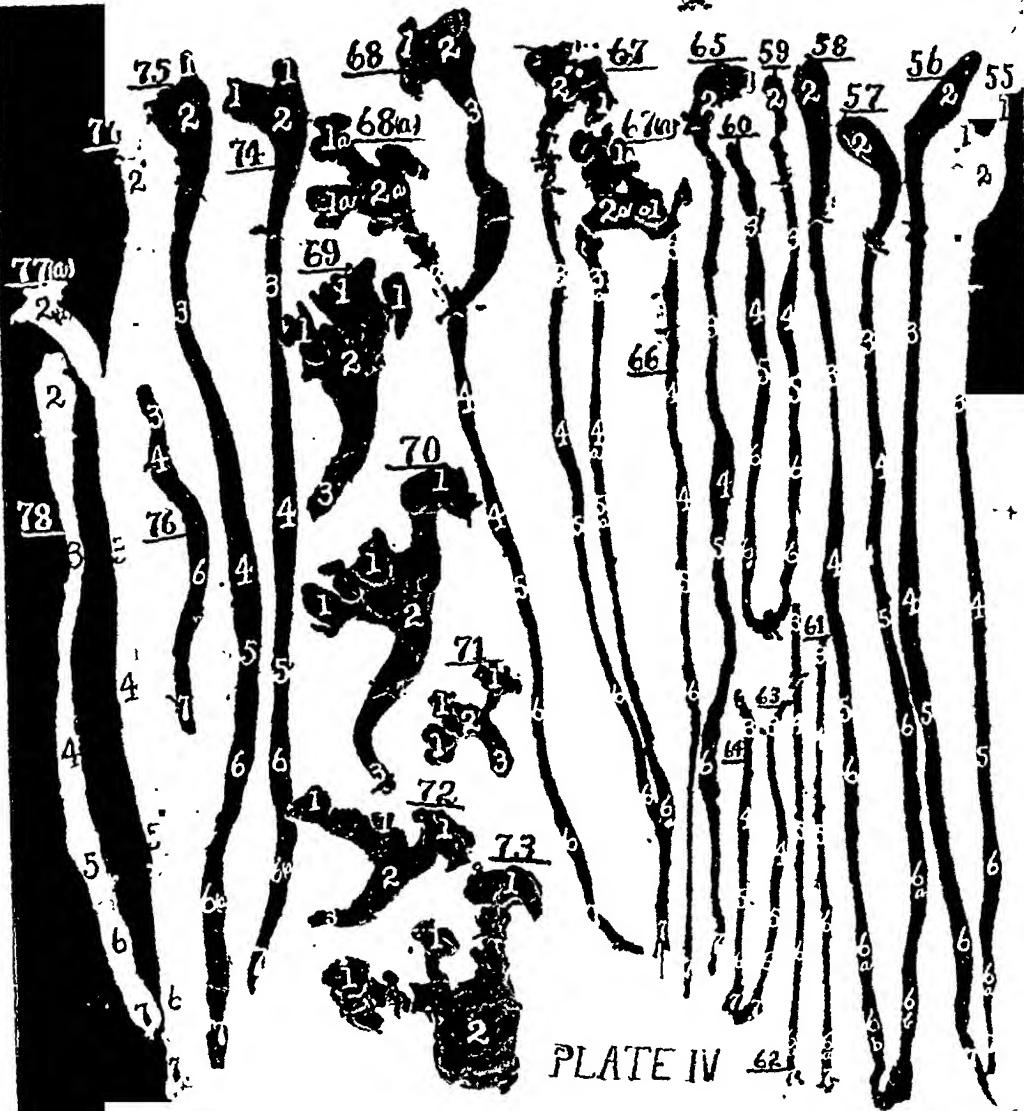


PLATE IV

PARAFFIN CASTS OF URETERAL CALYCES, PELVES, AND URETERS.

BY BYRON ROBINSON, M.D.,
OF CHICAGO.

SOME studies in paraffin and corrosion anatomy are here presented, demonstrating (*a*) three constant ureteral dilatations; (*b*) three constant ureteral constrictions or isthmuses. The specimens were painted with white lead before being photographed.

The plate here given (Plate IV) presents half-life size the form of the ureters filled with melted paraffin under equal pressure, demonstrating (*a*) the ureteral dilatations, spindles, or reservoirs (1, 2, 4, 6); (*b*) the ureteral constrictions, isthmuses, sphincters (3, 5, 7). Some different forms of isolated calyces and pelves of different ages and animals are also presented.

Nos. 55 (left) and 56 (right); man, aged forty years. This pair presents usual calyces (1, 1, left). The forms, non-symmetrical, of the pelvis (2, 2) are well developed, but differ markedly on each side. The proximal isthmus (3), left, distinct, distalward located; right (3), it is indistinct and distalward in location (symmetrical); size, non-symmetrical. The lumbar spindle (4), right, well developed; left, slightly developed; size, non-symmetrical, location symmetrical. The middle isthmus (5), left, indistinct; right (5), distinct; size unequal, location symmetrical. The pelvic spindle, left, one large proximal (6) and one small distal (6) right, an indistinct proximal (6) and a well-developed distal (6). The distal isthmuses (7, 7) are smaller in caliber than the proximal (3, 3). The right (56) is an inch longer than the left (55), which is rare.

Nos. 57 (left) and 58 (right); man, aged sixty years. This pair presents slightly developed, elongated, symmetrical

form and equality in size of pelvis (2, 2). The proximal isthmus, left (3), is indistinct and proximally located; right (3), well marked and distally located, non-symmetrical in location and unequal in size. The lumbar spindle, left (4), presents two small short spindles; right (4), a distinct proximal and a small distal one, non-symmetrical in location, unequal in size, similar in number. The middle isthmus (left) indistinct; right, marked, non-symmetrical caliber and location. The distal isthmuses (7, 7) are about equal in caliber with the proximal (3, 3). The right ureter (4, 4) is longer by three-fourths of an inch than the left (58). The pelvic spindle, left (6, 6a, 6b), presents three spindles; right (6, 6a, 6b) shows three small spindles, non-symmetrical in size, location, and number.

Nos. 59 (left) and 60 (right); boy, aged four years. This pair presents typical constrictions and dilatations from a young child. They present usual pelvis (2). Right, marked proximal isthmus (3), left less distinct, more distally located, proximal isthmus (3) non-symmetrical in location. Right, prominent lumbar spindle (4); left, marked lumbar spindle (4); bilaterally symmetrical in form and location. Bilaterally symmetrical in form and size, middle isthmuses (5, 5). Right, two pelvic spindles (6, 6); left, three (6, 6, 6). Practically bilaterally symmetrical. The distal isthmuses (7, 7) were less in lumen than the proximal (3, 3). Bilaterally quite symmetrical ureters.

Nos. 61 (left) and (right) 62, pair of dog's ureters presenting bilaterally distinct lumbar and pelvic spindles. The naked eye can note them, but the magnifying lens of four diameters demonstrated them well. (3, 3) Proximal isthmus, (4, 4) lumbar spindles, (5, 5) middle isthmuses, (6, 6) pelvic spindles. (7, 7) The distal isthmuses were smaller in lumen than the proximal (3, 3).

Nos. 63 (left) and 64 (right); newly-born infant. This pair presents distinct, bilaterally symmetrical in form and size, proximal isthmuses (3, 3). Marked bilateral lumbar spindles (4, 4). Right, prominent; left, well marked lumbar spindle.

Indistinct middle, bilaterally non-symmetrical, isthmuses (5, 5). Right, indistinct; left marked pelvic spindles (6, 6). Distal isthmuses (7, 7) and proximal (3, 3) about the same in lumen.

Nos. 65 (left) and 66 (right); man, aged sixty-six years. This pair of ureters presents the most typical forms of constrictions and dilatations, but they were injected with celloidine, which, after evaporation of the alcohol and ether, allowed regular contraction of the ureters.

Nos. 67 (left) and 68 (right); man, aged fifty-five years. This bilaterally double pair of ureters presents short, irregular, ill-defined calyces (1, 1, 1, 1). Bilaterally, symmetrically located double pelvis (2, 2, 2, 2). The distal pelvis (2, 2, 2, 2) are the larger, possessing larger and more defined calyces (1, 1, 1, 1). Right, the proximal pelvis is fairly developed, elongated (2, 2). The distal pelvis (2, 2) is flat, moderately developed. Left, the proximal and distal pelvis (2, 2, 2, 2). Right ureter, the proximal isthmus of the distal pelvis is limited in caliber (3). The proximal isthmus of the proximal pelvis is difficult to locate. It may be 3 or 3a. The distal portion of the right ureter of the double pelvis is single for over two-thirds of its length. Double lumbar spindle (4, 4). Indistinct middle isthmus (5), well developed pelvic spindle. Left ureter, the proximal isthmuses are ill defined though apparently well proximally located, and also presenting a bilaterally double lumbar spindle (4, 4, 4, 4). The left ureter is double for its whole length, having two orifices in the bladder, as demonstrated by the two pins inserted in them. It appears to coalesce at its distal end, but the lumen of each ureter is distinct. There appears to be bilaterally, non-symmetrically located two lumbar spindles (4, 4, 4, 4). The middle isthmuses (5, 5) are moderately developed. There is bilaterally, symmetrically located, and irregular in size, double pelvic spindles (6, 6, 6, 6). The distal isthmuses (7, 7) smaller in lumen than the proximal (3, 3). Double ureters have occurred four times in this series of 100 cases. Once bilaterally

double; twice unilaterally double; one unilaterally double pelvis and ureter for the proximal fourth.

No. 69. Pig calyces (1, 1) and pelvis (2).

No. 70. Man, aged ——; paraffin cast of calyces (1, 1), pelvis (2), and proximal isthmus (3).

No. 71. Paraffin cast of calyces (1, 1), pelvis (2), and proximal isthmus (3) of a newly-born infant.

No. 72. Paraffin cast of a pig. Calyces (1, 1), pelvis (2), and marked isthmus (3).

No. 73. Paraffin cast of a man. Calyces (1, 1), pelvis (2). The pelvis was pathological, dilating, irregular.

Nos. 74 (left) and 75 (right); man, aged forty-eight years. This pair of ureters presents well-developed pelvis, especially the left (2, 2). Indistinct, proximal, but non-symmetrical located proximal isthmus (3, 3), marked bilateral; symmetrically located, unequal in diameter and length, lumbar spindles, middle isthmuses (5, 5) bilaterally symmetrical, unequal in diameter, moderately marked. Pelvic spindles (6, 6, 6, 6) bilaterally double, non-symmetrical in diameter, location, and length. Distal isthmuses (7, 7) less in diameter than the proximal (3, 3). A rare feature is that the right ureter is three-fourths of an inch longer than the left.

No. 76. Segment of a sheep ureter, showing spindles, lumbar (4) and pelvic (6), with isthmuses, proximal (3), and a pelvic constriction at (a).

Nos. 77 (left) and 78 (right); man, middle age. This pair of ureters presents a double pelvis (2, 2) on the left, with divided ureter for its proximal fourth. The right ureter has a single pelvis (2) moderately developed. The proximal isthmuses (3) are bilaterally symmetrical in diameter, but not in location. The lumbar spindles (4, 4) are marked, bilaterally, non-symmetrical in diameter and location. Middle isthmus (5, 5) marked, pelvic spindles (6) left, a small and a large spindle (6, 6). Right, three consecutive indistinct spindles (6, 6, 6). The distal isthmuses (7, 7) were smaller in lumen than the proximal (3, 3). The left ureter (7, 7) is longer by one and one-half inches than the right (7, 8). The

calyces, pelves of the double ureter as well as the free pelves (69, 70, 71, 72, 73) of man and animals are the result of corrosion by HNO_3 . The ureteral isthmuses (3, 5, 7) are points liable to obstruction from calculi, flexion, or torsion. The ureteral dilatations (1, 2, 4, 6) are points for surgical intervention from ample lumen and wall. All surgery must be limited at the ureteral isthmuses (3, 5, 7) from limited diameter and wall for manipulation. Some of the specimens of this plate I removed at autopsies by the courtesy of Professor W. A. Evans, others were secured for me by Dr. Fred. Harris and the Cook County internes. Additional specimens were secured for me by Drs. Ludlow and Savage. Dr. William E. Holland executed the photograph. For aid in securing the specimens, I am indebted to Drs. W. A. Evans and Fred. Harris.

EMBOLIC GANGRENE OF THE LEG AS A SEQUEL OF ACUTE LOBAR PNEUMONIA.¹

BY CHARLES LANGDON GIBSON, M.D.,
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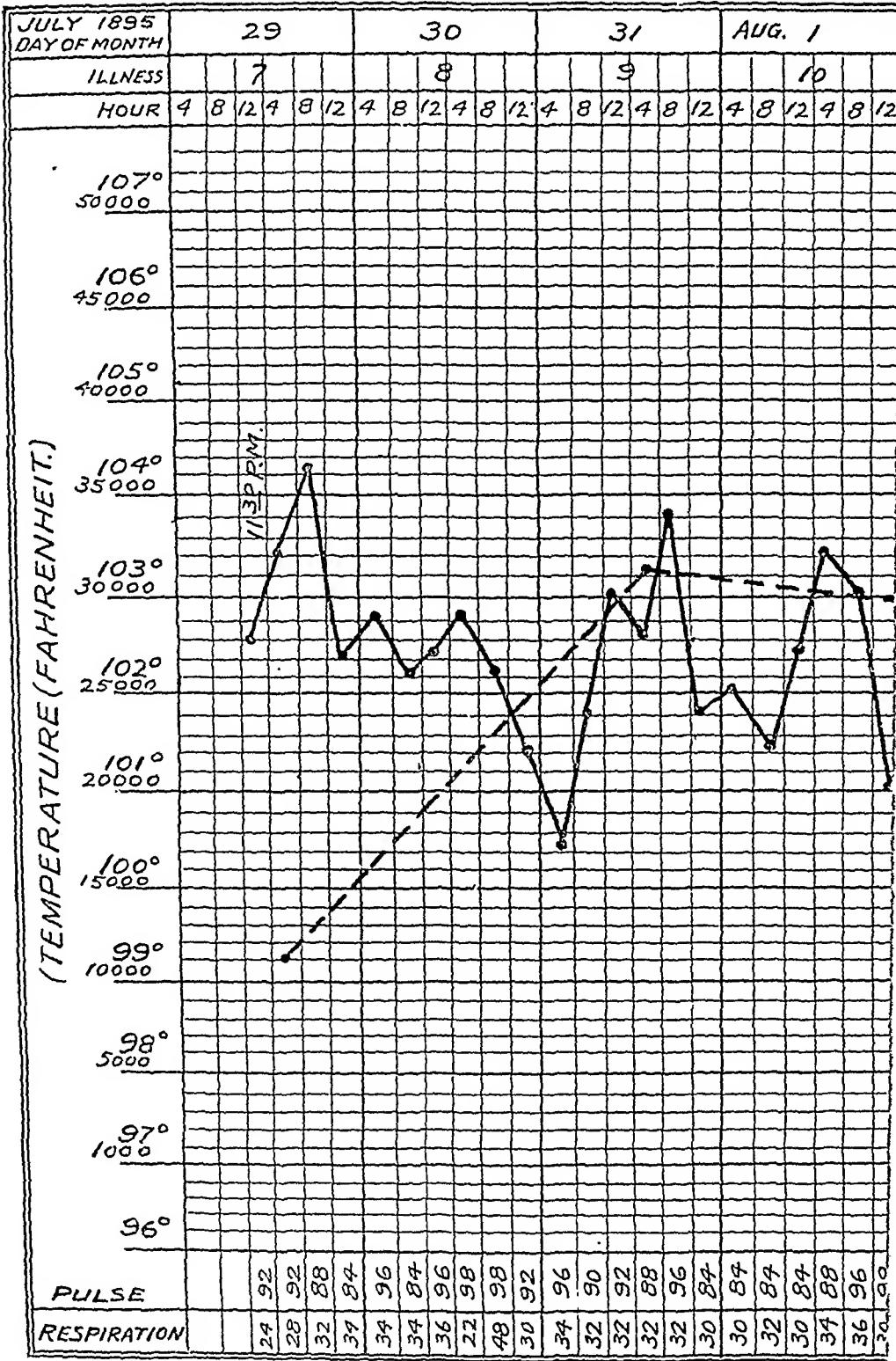
Attending Surgeon to St. Luke's and to the General Memorial Hospitals.

THREE cases of gangrene of the leg developed suddenly in the course of acute lobar pneumonia have come under my observation. The phenomena in each instance have been quite similar, forming so typical a picture that I have felt justified in attempting to establish a direct connection between the pneumonic condition and the subsequent gangrene of the extremity. That is to say, I believe that a coagulum from the pulmonary veins draining the affected area was dislodged, and came to rest at a site—presumably the bifurcation of the popliteal artery—where it caused permanent arrest of the blood supply.

The histories of these cases are as follows:

CASE I.—Joseph L., aged sixty-seven years, a native of Switzerland, was admitted to St. Luke's Hospital, July 29, 1895. Previous history negative. Moderate user of alcohol. Seven days ago, chill and pulmonary symptoms. Examination shows pneumonia of right lower lobe; some signs also in upper lobe. Temperature, 104.2° F.; pulse, 88; respiration, 32. Expectoration viscid, blood-streaked sputum. August 3, the twelfth day of his illness, temperature dropped from 103.4° F. to 100.2° F., and to 99° F. the next day. August 4, the thirteenth day, noted "signs of consolidation over the lower part of chest have entirely disappeared." On that day he complained of severe pain in the leg. August 6, the right foot and leg very painful and tender on pressure and cold, especially the foot, which has a purplish hue. No pulsations perceptible in arteries of foot or leg. No swelling nor oedema. Repeated tests for sugar in urine have remained negative.

¹ Read before the New York Surgical Society, April 8, 1903.



August 9. Good color and temperature half-way down leg, end of toes black.

August 14. There is a line of demarcation of junction of lower and middle thirds.

August 16. Some dulness and a few râles over right upper lobe, otherwise negative.

He was transferred to the surgical service, August 19. Amputation through lower third of thigh. Arteries at site of amputation plugged. (Dissection of leg later showed the clots extending into the upper third of the tibials, below which the lumen was free.) Recovered well from the operation, but the wound broke down, apparently from insufficient blood supply.

September 30. Flaps reopened, three inches of femur sawn off, flaps trimmed and sutured. This procedure also failed to meet the indications.

October 28. Second revision, about two inches of bone being excised, amounting to an amputation through the upper third. Again the wound broke down. He developed melancholia, necessitating transfer to Bellevue, January 3, 1896. Since that time there are no data concerning his condition.

CASE II.—Patrick J., aged forty-three years, married, cab-driver, was admitted to the medical division of St. Luke's Hospital, January 9, 1902.

Previous History.—Fracture of right leg seven years ago. Beer and whiskey drinker all his life. No specific history, no diabetes.

Fifteen days before admission, chill followed by pulmonary symptoms, developing into pneumonia. Defervescence on the seventh day, when he felt a sudden numbness in the left foot from the ankle down. He soon entirely lost sensation over this area, and it felt very cold to the touch, but was not swollen. Two days later experienced severe pain and tenderness in the popliteal space, in the calf, and over the anterior aspect of the leg below the knee about half-way between the knee and just above the area of numbness. This pain has continued unrelieved, and two days ago he noticed some discoloration over the anaesthetic area, particularly the toes, which has since increased rapidly.

Examination of chest shows only the signs accompanying resolution of a pneumonia of the left lower lobe. The left leg is swollen from pelvis down. The inner and under surfaces of foot

are cold, becoming gradually warmer up to the knee. Pressure on the leg is very painful. Below ankle all sensation is lost. Temperature ranges around 101° F. No glycosuria.

When I saw him at this stage, I was in favor of immediate operation; other views prevailing, the case passed from my observation.

January 21. "Area of cold has advanced up the leg for about two inches, the redness and pain to the middle of the leg."

Operation, January 24 (twenty-two days from first sign of obstruction), by Dr. F. W. Murray. Gas and ether anaesthesia, amputation through the condyles, which was well borne with the aid of free stimulation and a saline infusion.

February 4. "Edges of both flaps have broken down. Two sinuses with sloughy edges pass down to the bone."

February 26. "Sinuses closing down."

March 6. Discharged nearly healed.

Examination of the amputated leg showed a clot beginning in the popliteal artery and extending a short way down in the tibial arteries.

CASE III.—Mr. E. B., aged sixty-one years; lawyer; seen in consultation with Dr. Chapman, October 8, 1902. Previous history negative. Twenty-six days previously, sudden pulmonary symptoms developing in lobar pneumonia, right lower lobe. He had defervesced and was in good condition, when, twelve days previous to my seeing him, he had a sudden attack of numbness and intense pain in the left leg, and it was found that he had no sensation in his toes. Two days later the toes and leg had become markedly discolored, extending in a lesser degree up to the knee. Sensation being also lost and diminished.

When I saw him, there was a typical dry gangrene with well-marked demarcation at the middle of leg. Except for some moist râles over the right base, the lung was clear. His general condition was rather below par. His pulse was 88 and soft; temperature varying around 101° F.; respiration, 20. Urine, 1020, heavy trace albumen, no sugar.

Operation at St. Luke's Hospital, October 10. Gas and ether anaesthesia; a saline injection into the brachial vein started simultaneously with the operation. A rapid circular amputation through the lower third of the thigh was at once extended two inches higher, owing to the bloodless condition of the limb; even

at this higher level, most of the vessels, large and small, were plugged. The flaps were brought into loose approximation, a packing of sterile gauze intervening.

The operation was well borne, and the amputation wound healed slowly, but without necrosis or infection. His general condition was never satisfactory, and it was two weeks before the temperature became normal. Ten days previous to his death, he passed into an apathetic condition, and finally died six weeks after operation, with symptoms of progressive cardiac exhaustion. No dissection of the leg was permitted.

The symptoms of vascular obstruction seem to have developed in all three cases suddenly at or about the time of defervescence. The gangrene of the leg was on the same side as the pneumonia; but no significance is attributed to this fact. None of the cases showed any obvious kidney or cardiac changes, nor did the urine contain sugar. The previous histories showed no features of possible interest as etiological factors.

Such cases of gangrene as have just been described, occurring suddenly in the course of a pneumonia in previously healthy subjects, are admittedly rare. Welch alludes to Osler's having seen one such case due to embolism. I have asked a large number of practitioners as to their experience in this matter, with negative results. I have made as yet no systematic attempt to investigate the subject, but since 1895, when Case I occurred, have been on the lookout for some reports of similar experiences, without coming across any in the literature.

My belief that these cases were directly due to the pneumonic condition, and not to some other intercurrent or accidental process, are based chiefly on the following circumstances:

That a pathological condition accompanying pneumonia which would explain the purely mechanical process is stated by Welch to exist.

That the gangrene was of the dry form due to blocking of an artery.

That the typically sudden onset of symptoms was in favor of an embolism rather than a thrombus, beginning in the arteries of the leg proper.

That the patients showed no obvious vascular and cardiac lesions favoring the theory of the transferring to the leg of an embolism originating in such process.

That the age of two of the patients, sixty-one and sixty-seven, does not give greater weight to the theory of thrombosis due to senile changes, because I am able to cite two cases of sudden cerebral manifestations following pneumonia occurring in healthy men of thirty-five or thereabout.

In addition, it may be said that even if this theory of a direct mechanical sequence can be reproached with having lapses that prevent its entire acceptance, it is open to fewer such objections than any that may be offered in opposition.

With regard to the conditions at the site of the pulmonary lesion which may possibly give a direct origin to the embolic process, the evidence, it must be confessed, is meagre. Pathologists with whom I have conferred deny ever having observed any such thromboses of the veins necessary for this explanation. If existing, it must undoubtedly be exceptional, and it is possible that, in the absence of systematic observation of this point, its infrequent occurrence may have been overlooked, and we may yet have confirmations of the views here expressed. I find in Welch's article on "Thrombosis," in Albutt's "System of Medicine," Vol. vii, page 160, this statement:

"One sometimes finds in inflamed areas, less frequently under other conditions, the vessels, particularly those of small caliber, partly or completely filled with fibrillated fibrin, presenting such an arrangement and configuration as to indicate coagulation during life. . . . In croupous pneumonia such fibrinous masses are regularly present both in the capillaries and larger vessels of the hepatized area. These purely fibrinous coagula are of anatomical rather than clinical interest."

With regard to the possibility of the gangrene being due to localized arterial disease, while this view has to be enter-

tained, there is little to be said in favor of it. The most prominent argument, that two of these cases were over sixty years of age, is not enough. Such localized changes come for the most part considerably later in life. The starting-point is often referred to traumatism, and the history is that of a gradual process, that is, a slowly progressive thrombosis, contrasting sharply with the acute manifestations just described, which it seems more reasonable to refer to an embolic process.

Moreover, there is direct evidence in two of our patients that such was not the case, in that the clot only extended a short distance into the tibial vessels. Assuming then for granted that we have to deal with an embolic occlusion of the arterial supply, we come to the question of its possible origin in other portions of the arterial system. We are at once confronted with the fact that such possibilities do exist in many and varied forms, and the theory of probabilities would give the preference to such an origin rather than the apparently remote one which I have favored. Two of the patients come within the later periods of life, when cardiovascular degenerations chiefly occur, though, as a fact, most of the severer manifestations are developed at a still later period. Such people, for the most part, show either symptoms or visible external evidences,—thickened vessels,—not presented by my patients; although it is admitted that very considerable local changes may exist without these general manifestations.

We have also to consider the formation of cardiac thrombi, whose occurrence might be favored by the cardiac strain resulting from the pneumonia.

True cardiac thrombi are quite rare, and, if due to the pneumonia, should occur more particularly in the fatal cases when the heart flags, whereas those cases described were not of extraordinary severity, and the fact of their recovery is rather against such a theory. None of these cases presented signs of valvular lesions, so I doubt if the cause of the embolism can be ascribed to the transference of the vegetations which occasionally accompany such lesions. It does not seem

necessary to consider the possibility of so-called malignant endocarditis.

While admitting that these cases may be explained by the accidental manifestations of intercurrent previously existing cardiovascular changes, I prefer to hold to what seems to me the reasonable theory of a direct sequence of events referable to the pneumonia, with the hope that by calling attention to such a possibility others may be induced further to study these points.

The experience acquired in these cases furnishes the opportunity of considering some practical points in regard to when and where to amputate.

Shall we amputate while there is any active pneumonic process, and can there ever be sufficient urgency to require such interference before complete resolution of the pulmonary process?

Shall we wait for the establishment of a line of demarcation, or is it desirable to anticipate its formation?

These questions can be best considered by settling the question whether we shall ever anticipate the formation of a line of demarcation. My own feeling is *not* to wait, if the pulmonary condition favors intervention, in the belief that, even with the formation of a line of demarcation in the mid-leg, it will generally be better judgment to amputate above rather than below the knee. Moreover, the early operation might save more of the leg, assuming that the tendency of the clot once formed is to progress upward, as was shown in Case I, quite rapidly, and would have perhaps required properly to overcome it an amputation at the hip-joint. The extension of the clot and the promptness of re-established compensatory circulation cannot be accurately gauged, while the pulmonary condition can be more definitely ascertained. Therefore I should say, on general terms, wait till the lung condition allows, and then amputate without further delay. All three of these cases stood the operation well.

As regards the anæsthetic, spinal anæsthesia for those who choose to use it would seem to meet the conditions admirably. I prefer for general anæsthesia the risk of irritating

a damaged lung with ether to that of inviting collapse from chloroform of a heart enfeebled by a severe sickness.

With regard to the site, one should not be deterred from amputating at a point where the vessels are found obstructed by thrombi, because it is self-evident that the nourishment of any one point comes from a higher level. One will be guided by previous observation of the condition of the limb at the point of incision, that is, its degree of warmth and the activity of the return circulation after temporary local ischaemia from pressure of the finger. If, on division, the skin oozes freely, one may safely amputate at that point; if not, reamputate till this requirement is satisfied, even if the other tissues do not seem to respond to the same degree.

FRACTURES OF THE VERTEBRAE.¹

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IN a review by Dr. Rieder of cases of spinal surgery treated in the Hamburg City Hospital (quoted by Lloyd, ANNALS OF SURGERY, Vol. xvi, September, 1893), the cases were grouped as follows:

- (1) Injuries to the spinal cord without injury to the vertebræ.
- (2) Injuries to the spine treated without operation.
- (3) Injuries to the spine operated upon.

As an illustration of the first group, an instance is cited when a fall of fifteen feet upon the head resulted in anæsthesia of both lower extremities and trunk as far as the cervical vertebræ, with diminished sensation and muscular power of the upper extremities. There was violent pain in the neck and extreme sensitiveness to pressure over the cervical vertebræ, but no demonstrable dislocation or crepitus. The patient died in twenty-four hours in collapse accompanied by unconsciousness, meteorism, and dyspnœa. The autopsy revealed a rupture of the ligaments between the vertebral arches of the first, second, fourth, fifth, and sixth cervical vertebræ, with anterior luxation of the sixth and posterior dislocation of the seventh cervical vertebra, with rupture of the intervertebral cartilage. The cord was lacerated between the third and seventh pairs of cervical nerves, and there was hæmorrhage into the canal.

Of the five cervical cases treated without operation, the first one could not have been cured or improved by operation. Twelve days before admission to the hospital, the patient jumped headlong into the water and struck his head on the bottom. There followed immediately complete motor and sensory paraplegia, repeated vomiting, difficulty of swallowing, attacks of dyspnœa, incontinence of fæces and urine. Slight prominence of the first

¹ Read before the Chicago Surgical Society, April 6, 1903.

dorsal vertebra was observed. The autopsy revealed slight prominence of the fifth cervical vertebra; a piece of bone broken off and connected with the sixth cervical vertebra; cervical cord extremely soft and sunken in the region of the fourth and fifth roots; a cavity bounded by the pia mater anteriorly, and by a thin layer of cord tissue posteriorly, filled with necrotic shreds.

The second case treated without operation would have terminated fatally under any treatment. The injury was caused by a fall of fifty feet, resulting in fracture of the fifth and sixth cervical arches, with dislocation of the sixth upon the seventh cervical. There was a slight extravasation in the dural sac in the cervical and dorsal regions and complete destruction of the cord between the fourth and seventh nerves. In addition to the usual symptoms, the patellar reflexes were weak, and there was slight priapism.

The third case treated without operation might have been relieved by immediate operation. A piece of bone chipped from the anterior circumference of the sixth cervical vertebral body caused a wedge-shaped compression of the cord. The usual symptoms of cord compression were observed.

In the fourth case the injury consisted of a complete crush of the body of the sixth cervical vertebra. The ligaments between the vertebræ were not lacerated. The cervical portion of the cord from the point of fracture up to the third cervical vertebra was changed into a white paste, in which white and gray substances could no longer be distinguished. There were other injuries in this case, but the condition of the cord was such that no improvement could have resulted from an operation.

In the fifth case the patient was injured by being bent backward. There was slight tenderness on pressure over the sixth and seventh vertebræ, loss of motion and sensation in the lower limbs, and anaesthesia extended to a line somewhat above the nipples. The reflexes were increased; the rectum and bladder paralyzed. There was in this case fracture of the bodies of the sixth and seventh cervical vertebræ, with rupture of the ligaments and crushing of the spinal cord. Operation would in all probability have availed nothing.

Six cases of fracture of the dorsal vertebræ were not operated. In the first there was a transverse fracture and dislocation backward of the body of the twelfth dorsal vertebra, with total

paraplegia and anaesthesia of the legs and trunk to the umbilicus. The patient lived six months. At the autopsy an ascending degeneration of the columns of Goll, with chronic myelitis and atrophy of the lumbar cord, was found.

The second case consisted of a fracture of the dorsal body, with posterior dislocation of the lower fragment, and a detachment of a piece of the posterior part of the body of the eighth dorsal. There was complete destruction of the cord at the seat of injury. The reflexes were absent. Operation would probably not have benefited the patient.

In the third case there was crushing of the fifth dorsal with other injuries. The spinal cord was torn across at the seat of the spinal injury, and the patient died immediately after admission to the hospital. Operation would not have benefited this patient.

In the fourth case there was complete paraplegia in both legs and almost symmetrical anaesthesia as high as the umbilicus. The spinous processes of the fifth, sixth, and seventh dorsal were prominent and tender. At the autopsy the ninth dorsal body was fractured and a wedge-shaped piece was dislocated into the vertebral canal, so that the spinal cord was completely severed and the canal blocked.

The fifth case was one of direct violence, the patient being struck in the back while lying on the ground. There resulted a fracture of the sternum and fourth dorsal vertebra, which was dislocated backward, contracting the lumen of the canal. At the autopsy the cord was found softened at this point. Under extension and counterextension the anaesthesia finally disappeared down to the soles of the feet, but reappeared together with paralysis of the rectum and bladder. Patellar reflexes had disappeared.

In the sixth case there was fracture of the eighth and ninth dorsal vertebrae. The right leg and arm were paretic, but sensation was normal. The left arm and leg were normal; reflexes normal; bladder paralyzed. After the application of a plaster-of-Paris jacket, the bladder paralysis disappeared. The right arm also recovered and the leg greatly improved. The patient was dismissed from the hospital much benefited.

Some of the cases reported under the group, "Fractures of the Vertebral Column treated by Operation," are interesting.

A male aged twenty-four years fell on his back from a wall. Shock, copious bleeding from the left ear without injury of the

skull, fracture of the fifth and sixth dorsal vertebræ with deformity, complete paraplegia of motion and sensation from the umbilicus down, paresis of bladder and exaggerated reflexes, followed the accident. The patient was treated by extension and counter-extension, and finally by a plaster-of-Paris corset. There was a progressive increase in symptoms under this treatment, and in about a year after the accident the fifth and sixth spinous processes and vertebral arches were resected. Some fragments of bone pressed upon the cord. No injury to dura or cord was made out. There was no improvement, and the patient died two years after the accident.

At the autopsy the vertebral canal was found closed by fibrous tissue. The spinal cord was compressed and its structure on section was not recognizable.

The second case was that of a male struck on the left shoulder by a heavy block of wood. The accident was followed by the usual symptoms of injury to his cord. The patient was treated by extension. Ten days later he could move the toes of the right foot slightly. There was hyperæsthesia and feeble power of rotation. There was still further improvement, but at the end of a year his condition became worse. Careful electrical treatment failed. A year and three months after the injury four spinous processes and arches were removed in the mid-dorsal region by means of the chisel and mallet. The cord was almost completely destroyed, the fractured body of the sixth dorsal being pressed into the canal. There was an increase in the spastic symptoms lasting for some days after the operation, but no improvement. An immediate operation might have been of value in this case.

There is recorded a case of simple fracture of the laminæ of the last two dorsal and first lumbar vertebrae, the bodies also being crushed. Laminectomy was performed seven months after the injury. Four years later good use of the lower extremities was reported and no anæsthesia existed above the knees. (J. A. Wyeth, April 18, 1891.)

August, 1894, John A. Wyeth (*ANNALS OF SURGERY*, August, 1894) reported five cases of vertebral fracture. The first case was that of a male, aged twenty-one years, who was thrown from a locomotive, striking the rail and bounding from the track. The patient had lost all power of motion from the pelvis down. The paralysis involved both rectum and bladder.

There were severe pains in the legs and feet. Eight months after the accident, Dr. Wyeth performed laminectomy of the last two dorsal and first lumbar vertebrae. The bodies of these vertebrae were crushed in such a manner that the cord was partly divided, and the undivided part was compressed between the laminae of the vertebrae above and the crushed and displaced body below. The compressing bone was removed and the dura closed. Slight improvement in motion was immediate, especially in the feet. The improvement continued, and in four years the patient had good use of the lower extremities; could flex and extend the thighs and legs; anaesthesia had disappeared above the knees. The patient, however, had to use a cane or crutch in locomotion.

The second case was that of a patient ten years old, who, at the end of four months, still suffered paraplegia of motion and sensation from the level of the umbilicus, and also paralysis of bladder and rectum. No improvement followed a laminectomy of the sixth, seventh, and eighth dorsal vertebrae. The continuity of the cord was almost completely destroyed.

The third case was that of a patient aged sixteen years, who fell twenty feet. The accident resulted in paraplegia of motion and sensation below the hips, with paralysis of bladder and rectum. Plaster-of-Paris jacket was employed for six weeks. Eight months after the date of the accident, laminectomy of the eleventh and twelfth dorsal and first lumbar vertebrae was performed. The cord was small and soft, but not compressed. Pachymeningitis existed. There was no improvement.

In the fourth case a .38-caliber ball entered to the right of the spinous processes, penetrating the spinal canal through the right laminae of the third and fourth dorsal vertebrae. The usual symptoms of injured cord followed. Dr. Wyeth saw the patient seven months after the receipt of the injury and operated two days later. The bullet had cut the dura and the cord on the right side, and passed into the body of the vertebra. Some spiculae were removed, but there was no improvement in the paralysis.

The result of laminectomy sixteen hours after the accident is shown in the third case. The patient, a male aged thirty-four years, fell two stories. There followed complete paraplegia of motion and sensation; absence of patellar reflexes; deformity of fifth and sixth dorsal vertebrae; priapism; distention of blad-

der with urine. The next day incipient bed-sores over gluteal region were noticed. The operation was performed under chloroform-morphine narcosis. The spinous process of the fifth dorsal was found fractured and removed. The arch of the sixth vertebra was broken in its posterior section. The fractured piece, together with the whole posterior segment, was driven into the vertebral canal and materially reduced its lumen. The fractured spinous process had advanced under the skin, and the upper portion of the fragment was found lying upon and compressing the cord. This fractured arch was removed and the cord left free and surrounded by the uninjured dura. Two days later improvement began. Patellar clonus was noted on both sides. Plantar reflexes greatly increased on left side, the whole extremity responding violently, less intensely on right side; sensation not changed; functions of bladder and rectum normal. The patient was eventually on his legs all day, could walk for two hours without fatigue, and, according to his own statement, enjoyed at home excellent health.

I find reports of two cases of laminectomy for fracture of the laminæ of the first three lumbar vertebrae. (Dr. W. C. Arnison, Manchester, England.) In the first case operation was performed four weeks after the receipt of the injury. The patient was able ultimately to walk out of the hospital.

In the second case the operation was performed seven days after the injury. Great improvement in his general condition and a slight increase of muscular power resulted. (ANNALS OF SURGERY, January, 1897.)

In another case (Dr. E. P. Riggs) operation was performed four days after the injury for fracture of the laminæ of the last dorsal and first two lumbar vertebrae. Result: Sensation as far down as the knees; each foot can be slightly moved. (ANNALS OF SURGERY, January, 1897.)

Dr. W. L. Pyle reported the performance of laminectomy for fracture of the first lumbar arch six days after the injury. Girdle pain disappeared; general condition good; bed-sores healed, but there was no improvement in the paralysis. (ANNALS OF SURGERY, January, 1897.)

Dr. J. A. Romeyn gives four cases of entire recovery following laminectomy for fractured lumbar vertebrae. (ANNALS OF SURGERY, January, 1897.)

Six weeks after a fall followed by the usual symptoms of fractured vertebræ, a patient, aged fourteen years, entered the hospital for operation. Several days subsequent to the accident, he had chills with high temperature. During part of the time there were many fluctuations of temperature. Two weeks later a laminectomy of the eighth, ninth, tenth, and eleventh dorsal vertebræ revealed a layer of lymph an eighth of an inch in thickness. This was followed as far as the canal was exposed. The dura was incised four inches and a considerable quantity of cerebrospinal fluid escaped. The cord was not bruised or divided, but seemed smaller than normal. The fluctuations of pulse and temperature persisted to the end. The urine was ammoniacal and contained pus. There was no improvement. (Dr. J. A. Wyeth.)

A young adult was admitted to St. Luke's Hospital, Chicago, March 26, 1903, suffering from fracture of the fifth and sixth cervical vertebræ. He had complete paralysis of all the parts below the injury. The reflexes were abolished. Laminectomy of the fifth and sixth vertebræ was performed by Dr. W. H. Allport. The dura was torn about an inch. The cord was explored and no marked laceration discovered. The wound was sutured, gauze drainage being employed. The patient died March 29, laboring under great dyspnœa.

These cases have an important bearing on the subject of early operative interference.

While both early and immediate operations are more strongly recommended than formerly, even late operations are not always followed by negative results.

Dr. Oscar J. Mayer (*ANNALS OF SURGERY*, August, 1897) reports a case of laminectomy sixteen months after fracture. The patient had paraplegia of motion and sensation of the legs. He had to be catheterized, and the bowels were constipated. The bowels moved on the third day as the result of a purgative, but unconsciously. Patient was encased for seven weeks in plaster of Paris extending from the arm-pits to the toes. The only complaint at this time was pain in the bladder, especially during

irrigation. Upon the removal of the plaster, decubiti were observed on scapulæ, sacrum, heads of fibulæ, and both heels. The condition of the patient when finally admitted to the hospital was as follows: Spinous processes of first and second lumbar displaced to right and painful; incontinence of urine and fæces; paralysis and atrophy of lower extremities; only slight movement at hip-joint; knee- and ankle-joints more or less ankylosis.

Percussion of the quadriceps tendon caused clonic contraction of the muscles of the thigh, throwing the whole leg into vibration. There was livid discolouration of legs. At the end of May the patient could, with the assistance of furniture, move a few steps around the room. He could not sit on a chair on account of the ankylosis of the knee-joint. Cystitis improved; incontinence of urine and fæces persisted. At the end of June the patient could so use his thighs that he could throw his legs forward, and was able to insecurely stand and walk a few steps with the aid of crutches. Laminectomy, September 6, 1895. The laminæ of the first and second lumbar showed a decided recession from the normal. The dura was found adherent to the cord. After fifteen days, the patient for the first time asked for a vessel; the bowels responding to voluntary effort. Incontinence of urine continued. October 8 patient showed more control of leg movements. He left the hospital with portable urinal and used the crutches fairly well; November 27 walked with the aid of one stick; could hold urine an hour and voluntarily void it. The next few months improvement continued; could hold urine three or four hours; walked several miles; could walk up and down stairs without support, and later he was able to resume work. Patellar reflex and ankle clonus absent on both sides; plantar reflex exaggerated. It is reported that the symptoms enumerated before the operation, which have since disappeared, are the following: Spastic paraplegia; incontinence of urine and fæces.

Under the head of late operations, I might refer to one of my own cases in which the operation was done over a year after the injury on account of severe pain emanating from the seat of the injury. Laminectomy in the dorsal region was performed with a relief of pain, but there was none whatever of the paraplegia of motion and sensation.

Dr. E. H. Dawbarn in October, 1894, reported the complete

recovery of a case of laminectomy for simple fracture of the neural arches of the eleventh and twelfth dorsal vertebræ, performed two and one-half years after the injury.

An operation was performed in a case of fracture of the first three lumbar vertebræ two years after the injury. There was only improvement in the cystitis and bed-sores. (Dr. W. C. Arnison, Manchester, England.)

Symptoms of fracture of the laminæ are sometimes obscure and the diagnosis proportionately difficult. In a majority of cases there is a history of direct or indirect violence. The deformity is sometimes very slight. Occasionally it does not become apparent for some days. In some cases several weeks, and in others again a number of months, elapse before deformity appears. (Stanly.)

Certain sounds may be elicited at times by carefully changing the position of the patient, the hand being applied to the injured part. The spinous processes may be out of line and lateral mobility of the spines may be discovered. Obvious lesion of the spinal cord is more or less convincing. (Thornburn.)

Dr. Allen Starr (*American Journal of Medical Sciences*, July, 1892) discusses in a very interesting manner the subject of local anaesthesia as a guide in the diagnosis of lesions of the lower spinal cord.

"The study of motor disturbances, including the form of paralysis and of the variations in reflex activity, has made it possible to determine the situation of lesions in the spinal cord with some exactness. The level of the cord at which the various reflex actions are performed is quite well known, but the spinal cord has sensory as well as motor functions; and it is only within a short time that the disturbances in sensation occurring in spinal lesions have been utilized for purposes of diagnosis."

"It is not enough to ask the patient whether he feels the touch of cotton wool, or the tip of the finger, or the warm or cold test-tube, or the prick of the needle, or the sting of a faradic brush, nor is it sufficient to touch two parts exclusively. He should

always be tested upon two surfaces simultaneously and asked if any difference is felt between sensations."

Starr shows that a limited area of anaesthesia is produced by a limited lesion in the spinal cord; that as the lesion ascends the cord from its lowest limit upward, the area of anaesthesia extends in a different manner upon the surface of the body, and that the situation and shape of the area of anaesthesia are positive indications of the level of the lesion in the spinal cord. These facts are not wholly new.

"Situation of the anaesthesia in lesions of the lower part of the cord is such as to escape attention unless searched for; and as the patients lie in bed upon their backs and sensation is often preserved in the front of the legs and thighs, the examiner, being content with the investigation of these parts, is misled in supposing that there is no anaesthesia."

Starr reports six cases in which limited areas of anaesthesia aided the localization of the lesion.

He draws the following conclusions:

"As the location of the centres of control of the bladder and rectum appear to be uniformly affected together, they must be adjacent to one another."

"The control of the sphincters is lost when the lesion involves the lower three sacral segments, and the centres probably lie in the lower two segments of the cord."

"When these segments are destroyed, the sphincter of the rectum is relaxed, and there is no opposition to the introduction of the finger into the anus."

"The entire rectum also loses its power of contraction, so that it is only emptied by a pressure from above or by artificial evacuation."

"As soon as a few ounces of urine collect in the bladder, pressure overcomes the slight resistance of the sphincter, and the urine flows away."

"If, in a case of paraplegia, the mechanism of the bladder and rectum is not interfered with, these organs empty them-

selves naturally when full, in spite of or without the knowledge or control of the patient, it is a proof that the lesion has not destroyed the lower sacral segments of the spinal cord. In such cases the exact area of anaesthesia should be carefully determined."

He emphasizes the importance of determining the distribution of anaesthesia in lesions of the lower part of the spinal cord. He shows that, as the cord is invaded by disease from below upward, the area of the skin, which becomes anaesthetic, increases in extent, and that the shape of the area is characteristic, so that from the study of the area, the extent of the lesion can be determined, and he draws attention to the value of a careful study of the disturbances of sensation in the diagnosis of the situation of lesions in the spinal cord and cauda equina.

The injuries under consideration when located below the first lumbar vertebra, and when the traumatism involves only the cauda equina, seem more amenable to treatment than those above.

Like the nerves of the periphery, those of the cauda equina are resistant to traumatism. Whether compressed or divided, they recover as soon as the compression is removed or the severed ends united. Delayed operations are likewise here followed by better results. (*ANNALS OF SURGERY*, July, 1896. Samuel Lloyd.)

Physiological evidence is in favor of regeneration of the nerve roots of the cauda equina. The absence of spontaneous recovery indicates the pressure of a mechanical obstacle to recovery. Some cases will recover spontaneously,—cases, probably, where there has been no extensive tearing of the roots. Thorburn is of the opinion that we should not operate here too early, say at the end of six weeks, if there has been little or no recovery, or if recovery has ceased. Too long a delay will result in secondary degeneration, which of course impairs the prognosis.

Recoil seems to be of much more frequent occurrence than is generally supposed. In a series of experimental frac-

tures in twenty-four children and eight adults, where the cord was either badly contused or entirely severed, the bones were found in place.

Post-mortem examination has shown that in two or three days after injury myelitis sets in and probably sclerosis, and in three or four months the cord has been converted into cicatricial tissue. This would favor early operation.

It is said that in favorable cases improvement begins by sudden and almost immediate return of sensibility. Motor repair is slower, but progressive from above down.

In reference to technique, Dr. Wyeth employed the following:

A free incision just over the spines, division of the attachments close to the bones with scissors or elevator, strong retraction, and iodoform-gauze packing to arrest bleeding. When well exposed, the laminæ are gnawed away in bits, first by a round rongeur, and when an opening is effected, by the more rapid cutting fenestrated rongeur. After an exposure of the full length of the injured region, and all bleeding stopped, the dura is carefully punctured, and as the first few drops of cerebrospinal fluid escape, the grooved director having been inserted, the dura is split open in the middle line. This membrane should be closed by a continuous catgut suture. A wick of iodoform gauze running from the dura out of the lower angle of the wound is inserted; dry dressing over all. His cases healed without suppuration. The outflow of cerebrospinal fluid continued from two to four days in all but one case, in which it leaked out for several weeks.

The question of deliberately opening the dura in all cases is questionable.

Chipault has called attention to one sign which indicates the integrity of the meninges, viz., the motion in the dura depending upon the pulse and respiration. The absence of this, in addition to conditions which do not now concern us, indicates a ring of adhesions between the membranes and the cord, shutting off the circulation of the cerebrospinal fluid. Accord-

ing to Chipault, this pulsation is not present when the membranes have been the seat of a pathological compression either extra- or intradural; but it returns in a few minutes after the removal of the compression, if it has not been too prolonged or too intense. He looks upon the return of the pulsation as a good sign. Should it not reappear, it is because the compression has produced some intrameningeal lesion which should be explored.

There is evidence to show that surgeons seldom do a sufficiently large and complete operation. It has been my practice to satisfy myself of the freedom of the cord from compression above and below the opening made by passing a probe upward and downward, of course outside of the dura. Haemorrhage is not particularly troublesome, except in the cervical region, which in one instance was followed by death in consequence of a lesion of the vertebral artery. Efforts should be made to preserve the periosteum, since Ollier has shown on dogs that, after a subperiosteal resection, a very good osseous canal has formed. Chipault (*Lloyd's Review, ANNALS OF SURGERY*) has observed that in five children the same result was noticed. In three it was demonstrated by palpation, and in two by a post-mortem.

Experiments have been made to determine the possibility of bringing into apposition and securing the union of the two ends of the cord. Chipault found in two post-mortem cases that the retraction of the ends and the extent of the sclerosis necessitated the resection of several centimetres, after which the lack of elasticity of the cord and the resistance of the ligaments of the pia mater oppose the approach of the healthy ends. Where, however, a recent section has been made by a cutting instrument, suture of the cord, which is in reality a suture of the membranes, is possible on the cadaver.

Improvements in results must come from prompt and more extensive operations, the removal of all portions of bone that encroach upon the cord, reduction through open wound, silver-wire suture when necessary and practicable, immobiliza-

tion, and the discontinuance of the use of the mallet and chisel in operating.

The higher the injury the greater seems to be the mortality; particularly does this apply to lesions in the cervical portion of the spine. Some deaths from haemorrhage of the vertebral artery during operations in the cervical region have been reported.

When the lesion is high and accompanied by respiratory difficulties, anaesthesia becomes not only difficult but dangerous, and several deaths from chloroform and ether have been reported.

The following conclusions seem reasonable:

(1) Laminectomy is superior to a simple reduction of the deformity, since, in fractures of the arches, reduction has no certain effect upon isolated fragments, and reduction alone has hastened death.

(2) Reduction may be more rational when effected through the open wound of laminectomy.

(3) Simple reduction is useless where there are clots or adhesions sufficient in themselves to account for the spinal disturbance.

(4) In cases of cervical luxation without fracture, simple reduction has given good results.

(5) It is possible to still further improve the prognosis of reduction in simple cervical luxations by making the reduction with the arches exposed and employing silver-wire suture of the processes to prevent relapse.

In consideration of the distressing prognosis in lesions of the cervical region, an operation appears strongly indicated.

Degeneration is observed wherever the narrowing factor is not removed.

The treatment of vertebral fractures without operation offers a chance of success only where there exists little or no disturbance of the spinal cord, such as paralysis of a single group of muscles, one-sided paralysis, or partial disturbances of sensibility, etc.

In all cases where the usual assemblage of symptoms indicate a severe alteration of the cord, only prompt operations directly afford the best chances of securing improvement or cure.

It is Dr. Mayer's opinion (*ANNALS OF SURGERY*, Vol. xxvi, August, 1897, page 218) that, upon the evidence of statistics of recent years, an operation is justified no matter how doubtful the case may appear. While the operation is essentially experimental and its results problematical, the striking cures accomplished within recent years must spur us on to the performance of an operation.

DISLOCATION OF THE OUTER END OF THE CLAVICLE.

WITH REPORT OF FOUR CASES.

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DISLOCATIONS of the outer end of the clavicle may be divided into two classes: 1, Cases in which the coracoclavicular ligaments are completely torn; and, 2, cases in which a complete rupture of the coracoclavicular ligaments has not occurred.

By physical examination, we can distinguish these two classes clinically.

Dislocations of the outer end of the clavicle, without complete rupture of the coracoclavicular ligaments, can be treated successfully without operative intervention.

Dislocations of the outer end of the clavicle, with complete rupture of the coracoclavicular ligaments, require operative procedures to secure satisfactory results.

I.

Six out of forty-four original articles on dislocations of the outer end of the clavicle mention the pathology of the condition. Robert T. Morris¹ and James E. Moore² each report one case in which complete rupture of the coracoclavicular and acromioclavicular ligaments was observed at operation. T. H. Manley³ states that in all cases of dislocations of the outer end of the clavicle the capsule of the joint is completely torn and the coracoclavicular ligaments probably ruptured. He reports four cases, but makes no mention of actual experiments or observations concerning the nature or extent of the injury. Dr. Krecke⁴ reports two cases in which he determined at operation that a complete rupture of the coracoclavicu-

lar ligaments existed. He states that a complete dislocation of the outer end of the clavicle can occur without complete rupture of the coracoclavicular ligaments, but gives no proof in support of the statement. He states, also, that in all, "severe" cases the coracoclavicular ligaments are completely torn. Paul Poirier and Henri Rieffel⁵ record observations on two cases treated by operation. From these cases, and from experiments on cadavers, they believe (1) that the acromioclavicular ligaments are torn in all cases; (2) that the conoid ligament is sometimes torn in incomplete dislocations; (3) that the conoid ligament is always torn in complete cases; (4) that both conoid and trapezoid ligaments are frequently completely torn in complete cases. They admit, however, that the trapezoid ligament may not be completely torn in cases of complete dislocation. N. D. Edwards⁶ reports a case of dislocation of the clavicle under the acromion process. He states that the coracoclavicular ligaments are torn in this variety of dislocation, but records no observations or experiments to support the statement.

My experience corresponds closely with that of Poirier and Rieffel. I have operated on two complete cases, and observed complete rupture of the coracoclavicular ligaments in each. I have produced dislocations of the outer end of the clavicle eight times by experiments on cadavers. In three experiments the deformity was characteristic, but the outer end of the clavicle was not freely movable. In these cases the coracoclavicular ligaments were only partially torn. In three shoulders, in which more injury was done, the clavicle was freely movable, and on examination the coracoclavicular ligaments were completely ruptured. In two cases I was unable to produce the dislocation without first severing the acromioclavicular ligaments. I then produced the dislocations and found the coracoclavicular ligaments completely torn. In attempting to produce the desired dislocation in two cases, I fractured the clavicle, rendering the subjects unfit for further experimentation. In all cases the acromioclavicular ligaments were completely torn, but the tearing was irregular. I did

not succeed in detaching the superior acromioclavicular ligament from the clavicle, as was observed to have been the case in the patient reported by Moore.²

II.

The reports of the cases of dislocations of the clavicle are of little value in aiding us to determine the extent of the injury from the symptoms present. The reports by Tracy,⁷ Krecke,⁴ Budinger,⁸ and Albers⁹ are the only ones that discuss the deformity with any degree of definiteness. On account of these brief reports, I believe it to be impossible to draw definite conclusions. However, I think that certain important signs will enable the surgeon to determine positively if a complete rupture of the coracoclavicular ligaments exists. I shall discuss these signs separately.

(a) Inability to reduce the dislocation. There are three cases of this character recorded. Moore² examined his case at operation, and noted that the coracoclavicular ligaments were completely torn. The two other cases were reported by Nicaise¹⁰ and Reynier.¹¹ These cases were not exposed by incision. Moore obtained a good result in his case. The results in the other cases were very unsatisfactory.

Reynier claims to be the first to observe a case of dislocation of the outer end of the clavicle that could not be reduced. He reported his case in 1877, and therewith mentions a case observed by M. Nicaise. Nicaise reported his case in the *Lancet* in 1876. Reynier's observation may have been made first, but Nicaise's report was first put into print.

(b) Extent of the deformity. Only four authors write definitely on this subject. In Albers's case the outer extremity of the clavicle could be separated six centimetres from the articular surface of the acromion. He operated and obtained a good result. He does not mention the coracoclavicular ligaments; but it is reasonable to suppose that they were completely torn. Budinger⁸ reports a case in which the displacement was four centimetres. He operated, but, like Albers, does not mention the coracoclavicular ligaments. Krecke⁴

reports two cases in which the displacement was three centimetres.

From observations on cadavers, and from examining two cases herewith reported (*vide infra*), I believe that in all cases where the articular surfaces of the clavicle and acromion can be separated one inch, the coracoclavicular ligaments are completely ruptured.

(c) Recurrence of the deformity (mentioned by Albers,⁹ Hofmann,¹² and Krecke⁴) is a symptom which indicates serious injury to the soft parts, and, I am inclined to believe, does not occur unless the coracoclavicular ligaments are destroyed.

(d) Longitudinal separation of the acromion from the clavicle. In one case (*vide infra*) I was able to separate the acromion from the articular surface of the clavicle one-third of an inch. Operation revealed a complete rupture of the coracoclavicular ligaments. The test was applied as follows: I stood on the injured side of the patient, facing the shoulder. I then placed one hand in the patient's axilla and drew the humerus towards me, resting his elbow against my abdomen. By using slow and steady traction, I was able to separate the articular surfaces of the clavicle and acromion about one-third of an inch. In the same case I could grasp the outer end of the clavicle and easily elevate it above the acromion.

I should diagnose probable complete rupture of the coracoclavicular ligaments in all cases of dislocation of the outer end of the clavicle presenting any of the following conditions: (1) Inability to reduce the dislocation. (2) Separation of the articular surfaces more than one inch. (3) Ability to produce a longitudinal separation of the articular surfaces one-third of an inch, or to easily elevate the outer end of the clavicle. (4) Marked tendency to recurrence of the dislocation.

III.

There are many examples of dislocations of the outer end of the clavicle treated successfully without operation. From the symptom of such cases, it is probable that the coraco-

clavicular ligaments remained intact. I can find no report of a case presenting symptoms of dislocation of the outer end of the clavicle without complete rupture of the coracoclavicular ligaments that was not treated successfully without operative interference. Thirty-six such cases have been recorded.

The second part of proposition III, namely, that dislocations of the outer end of the clavicle, with complete rupture of the coracoclavicular ligaments, require operative procedures to secure satisfactory results, is not easily proven. I can find reports of eight cases, with doubtless complete rupture of the coracoclavicular ligaments, treated without operation, in which the results were either complete failures or were unsatisfactory.

Nicaise¹⁰ and Reynier¹¹ report a case in which the deformity could not be reduced. Of course, the results were unsatisfactory. Newman¹³ reports a similar case. The results were not given, as the patient went to "a bone-setter" for further treatment. This suggests that the result was not perfect. Mr. Hulke¹⁴ treated a case of complete dislocation of the outer end of the clavicle, and states that four weeks after the injury the patient had fair use of the arm. Dr. Albers¹⁵ treated a case of complete dislocation without operation, and states that after several weeks' treatment there was deformity and considerable loss of function. T. H. Manley³ reports two cases (I and III) with poor results. These cases were neglected, and do not give a fair test of the non-operative treatment. W. F. Gibb¹⁶ reports a complete case treated without operation. The result gives us no information, the patient died eight days after being injured.

I can find the report of one case (Davis¹⁷) of dislocation of the outer end of the clavicle, with symptoms pointing to complete rupture of the coracoclavicular ligaments, that was treated without operation and a satisfactory result obtained.

From the foregoing reports (a good result in one out of nine cases), it is evident that in cases of dislocation of the outer end of the clavicle, with symptoms pointing to complete rupture of the coracoclavicular ligaments, non-operative treatment will rarely give satisfactory results. On the other hand, opera-

tion in these cases has been successful without exception. Fifteen cases operated and no failures.

I shall describe briefly the operated cases.

CASES I and II (Paul Poirier and Henri Rieffel)⁵ were complete dislocations of the outer ends of the left clavicles. The bones were drilled and silver wire used to approximate. On the twenty-second day in one case, and the twenty-third in the other, the results were perfect.

CASES III and IV (Dr. Albers)⁶.—The patient was twenty-eight years old, and received the dislocation by falling. The clavicle and acromion were separated six centimetres. Non-operative treatment was tried six days, but was unsatisfactory. The operation consisted of incision, drilling bones, wiring with heavy silver wire, and approximation of soft structures with catgut. The result was perfect in four weeks. Albers's second case corresponds to the one given.

CASES V and VI.—Morris¹⁸ reports two cases treated by drilling into the acromion and end of the clavicle, and retaining the bones in position by inserting a silver dowel-pin, one inch long, into the drilled holes. The joints were ankylosed, but the results were perfect.

CASE VII.—J. O'Connor¹⁹ operated a case as follows: Curved incision, holes drilled, and two wires passed (does not mention kind of wire used); wound drained with iodoform gauze. There was no infection. The patient was discharged on the thirty-first day with a perfect result.

CASE VIII (Reynier)²⁰.—Two months after the injury occurred, Reynier exposed the dislocation; severed a portion of the trapezius to complete reduction, and wired the bones in position with silver wire. The result was perfect. Reynier claims to be the first to wire a dislocated clavicle; also states that he has wired two other cases, but does not report them in detail.

CASES IX and X (Dr. Krecke)⁴.—Krecke treated two cases by exposing the bones and wiring them in position with two silver wires. Good results were obtained in each case.

CASE XI.—Büdinger⁸ reports a case treated as follows. Exposure of joint; drilling and passing silk sutures. He could not retain the fragments satisfactorily with this method, so drove a drill-point horizontally through the acromion into the clavicle five centimetres. This retained the bones in perfect position. The wound remained clean. On the eighteenth day the drill-point was removed, and seven days later the patient was discharged cured.

CASE XII (Moore)².—On the third day, Moore exposed the joint by incision; reduced the dislocation, and retained the bones in position with silver-wire sutures. Five weeks later the wires were removed. The result was satisfactory.

These reports demonstrate the advisability of operation in all cases in which we might expect doubtful results by non-

operative treatment; and the results may be termed doubtful when a complete rupture of the coracoclavicular ligaments can be diagnosed. There is only one case¹⁷ reported, with symptoms pointing to complete rupture of the coracoclavicular ligaments, that terminated favorably without operation. G. Lafon²⁰ recognized that the non-operative treatment was often inefficient. He states that the ordinary bandages and apparatus often fail to give good retention of the parts. Then suturing seems advisable. Dr. Albers⁹ had some unsatisfactory results in treating dislocations of the outer end of the clavicle with non-operative methods. In a paper published in 1894 he advised operation in all complete cases. T. H. Manley³ states that the treatment of this condition is very unsatisfactory. He reports four cases, but has had no experience with the operative treatment. Carl Scholz²¹ speaks of the difficulties met with in handling some cases. He says that most surgeons pass rapidly over the subject of these dislocations, giving one the impression that they have not much faith in their own methods. He favors operative treatment. Budinger⁸ says that the results in these cases are in many instances bad. He favors operative treatment, and is of the opinion that, even if a dressing or apparatus can be found that will hold the parts in position, there is always the danger of gangrene or decubitus ensuing.

Although most writers who have studied the subject favor operation, many cases are reported with good results obtained by non-operative treatment. However, most of these reports are of single cases; in only one have we reason to believe that the coracoclavicular ligaments were completely ruptured; and many times the cases were reported to demonstrate a dressing or apparatus supposed to be especially effective in treating this form of dislocation. With regard to the more severe cases, there are a few statements, which I find quoted without references, that are of more or less interest. Hoffa says that most complete cases recover without marked disturbance of function, although with more or less deformity. Discher, König, and Tillmanns state that, even when marked displacement results.

function may be perfect. Von Bergman and von Volkman say that they have never observed any disturbance except deformity to follow this dislocation. Defranceschi saw in three cases complete restoration of function despite the deformity. Bardenheuer, on the other hand, has seen marked disturbance of function in a case treated with care and thoroughness; and Hamilton saw two cases in which the disturbance of function was so marked that the patients could not raise their arms from their sides. I believe that the diversity of opinion that has existed in regard to treatment strengthens the arguments that I have been supporting. If the indication for operative treatment depends on the extent of the injury, a pathologic diagnosis must be made before the proper treatment can be advised. If a pathologic diagnosis is ignored, or cannot be made, the opinion of the surgeon, regarding treatment, will depend entirely on the type of cases he has treated. For this reason, radical statements concerning treatment should have their sources investigated before being accepted. The advice of Dr. Krecke on this subject appeals to me as being reliable and practical. He advises operation in complete cases in which the deformity is marked. He is of the opinion that in most of these cases the non-operative treatment is unsatisfactory, and states that operation is without danger, is easy to perform, and gives good results.

METHODS OF OPERATING.

Cooper was the first to do the open operation. In 1861, he exposed a dislocation, resected the ends of the bones, and retained them in position by drilling and uniting them with a suture. Although he obtained a good result, the operation did not come much into use till 1889, when Paci employed it. In the same year (1889) J. Wolff sutured a case with silver wire. The result was good, but, as a fistula remained, the wires were later removed. Following these cases, Poirier, Rieffel, and Le Bec report similar ones. In 1894 Albers reported a case wired successfully; and Krecke recorded a similar one in 1897. Although incision, drilling, and wiring have been generally

used in treating these cases, other methods have been resorted to. In 1885 Baum passed carbolized silk, subcutaneously, through the end of the ligamentum acromioclaviculare and coracoclaviculare, replaced the dislocation, and tied the ends over a roll of adhesive plaster on the skin. Bardenheuer recommended the Malgaigne clamp, but reports no cases in which it was used. Morris, in 1895, treated two cases by incision, drilling the articular surfaces of the acromion and apposed end of the clavicle, and inserting a stiff silver dowel-pin, one inch in length, into the drilled holes. The two articular surfaces were then pushed together and remained easily in the normal position, held by the dowel-pin. Budinger treated a case by driving a long drill-point through the acromion into the outer end of the clavicle. This held the bones in position, and a good result was obtained. The drill was removed on the fourteenth day.

The most approved method is exposure of the joint by incision; drilling the clavicle and acromion; passing and tieing two absorbable sutures; approximating ligaments and fascia with fine catgut; suturing the skin wound with silkworm gut. Drainage is not necessary. In operating old cases, it may be necessary to free the clavicle from cicatricial tissue before complete reduction of the dislocation can be accomplished.

There is some diversity of opinion with regard to the material to be used in suturing the bones in position. Silver wire has generally been selected. I believe that absorbable material will be more satisfactory; Moore is of the same opinion. The wire sometimes becomes a source of irritation, and its removal may become necessary. Wolff and Moore report such cases.

CASE I.—A male, twenty-nine years old, was thrown from an express wagon, striking on his left shoulder. Examination showed an upward dislocation of the outer end of the clavicle which slightly overlapped the acromion. The displacement was not marked and the clavicle was not easily movable. Reduction was easily accomplished by making traction on the arm. The dislocation did not recur. A strip of adhesive plaster was placed

over the outer end of the clavicle and under the elbow. This held the bones in position. On the twenty-second day the plaster was removed, and on the thirtieth day the patient resumed work. There was very little deformity and no impairment of function.

CASE II.—Herman J., a miner, thirty years of age, was thrown from a rapidly moving car. Examination showed a dislocation of the outer end of the right clavicle. The clavicle overlapped the acromion one inch, and was easily movable. It was also possible to elevate the clavicle from the acromion. The dislocation was easily reduced, but recurred promptly on releasing the parts. Various dressings were tried for four weeks; still, the clavicle was movable and the dislocation recurred. Operation was then performed: Incision; freshening articular surfaces with a curette; drilling; passing two No. 3 chromicized catgut sutures through the drilled holes; tying the bones in position; suturing the superior acromioclavicular ligament with No. 1 plain catgut; closure of the wound, without drainage, with silkworm-gut sutures. The wound healed by primary intention. Six weeks after the operation was performed the patient resumed work. The deformity was slight. Function seemed perfect.

CASE III.—Harry Y., a conductor, thirty-four years old, came to me with the following history: Eighteen months previously he received an injury to his shoulder by being thrown from a caboose. His treatment consisted of local applications and carrying the arm in a sling. He had considerable motion in the forearm and some in the arm, but the entire extremity was very weak. Voluntary movement of the arm was painful. Examination showed a drooping of the affected shoulder, with separation of the articular surfaces of the clavicle and acromion one-half an inch. The outer end of the clavicle was moved with difficulty.

Operation.—The joint was exposed and the articular surfaces freshened with a curette. The dislocation could not be reduced on account of the clavicle having grown to the coracoid process. The clavicle was then freed by passing a chisel along the under surface of the bone. The dislocation was then reduced, the bones drilled and wired with two silver wires, and the soft parts closed without drainage. The wound healed by primary intention. Very little deformity remained, but function returned slowly. Seven months after the operation was done the arm was

strong enough to be used for ordinary work. Motion was not limited or painful at this time.

CASE IV.—I am indebted to Dr. R. Sonnenschein for the report of this case.

A man, thirty-five years old, was injured by a heavy box falling against the posterior aspect of his shoulder. Examination showed the outer end of the left clavicle to be displaced one inch above the acromion. An X-ray examination verified the diagnosis. The dislocation could be reduced easily, but recurred as soon as the parts were released. Operation was done as follows: Exposure of joint; drilling of clavicle and acromion; insertion of two heavy silver wires; closure of soft parts with catgut and silkworm gut. The patient progressed favorably, but there was a slight superficial infection. Six weeks later the extremity was still weak, but was improving. Motion was somewhat limited when the arm was elevated beyond the horizontal position.

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METHOD OF RETAINING ENDS OF FRACTURED
BONES IN APPPOSITION DURING FIXATION
BY PLASTER-OF-PARIS DRESSING, ETC.

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FRACTURES capable of receiving a fixed dressing at any time in their treatment may be so treated at the outset, provided ample room by cotton padding and incision of the whole length of the dressing be made at the time of application to allow for swelling incident to such fracture. The habit of putting on a pillow splint to-day, and a board splint to-morrow, and a plaster splint next week, is in my opinion a useless barbarity to the patient, when under the influence of an anæsthetic the bones may be adjusted at the first visit and kept in a firm but yielding case by a fixed dressing of lino, starch, plaster of Paris, or silicate of potash.

The lino may be used when lightness is especially desirable, fortified by a thin strip of splint taken from board, the same as used at the back of picture frames; plaster of Paris or silicate of potash when greater strength is demanded, as in bones of the lower extremity.

I have practised this method in a great many cases, and have yet to meet the first ununited fracture or the first strangulated extremity; when the cases are compound, ample fenestra can be made for drain and dressing if infected.

The essential features of this treatment, as important as the fixed dressing itself, are the ample padding over prominences and where swelling will occur, and, most essential, the splitting down to the skin of the whole length of the plaster splint.

As the limb swells the cast expands, as it contracts the slot may be made larger and brought together with adhesive strips.

There is no splint that will adapt itself to the contour of the parts as this, nor give all-round support as well. It is there to stay until the union of bone takes place; or, if the limb requires passive motion, the shell may be removed and replaced at will. When we have fractures in the middle of long bones, it is not so difficult under an anæsthetic to adjust the ends and fix them by the plaster; but when near the extremity of the bone, as in supracondyloid fractures of the humerus, any one who has seen many of these breaks knows how strong the tendency to overriding is, and how difficult it is to overcome by manipulating the arm and forearm with the hands, especially when the line of fracture is oblique, as it generally is from indirect violence. In few fractures near a joint do we have greater and quicker swelling than those near the elbow, so that the fixed dressing has odds against it there if anywhere; and yet I have used it over and over again without detriment, but with benefit to the patient. I have devised a method, new to me at least, of holding the errant ends of bone in position while the plaster dressing is applied.

Having put the patient to sleep and washed the arm, I take two or three strips of bandage, smear them with vaseline, and apply one strip around the humerus above the seat of fracture, one just over the seat of fracture, and the third on the forearm just below the elbow. These strips are given to two assistants, and under your direction the upper one may be pulled back, the lower one down, and the middle one tightened to keep the bones from tilting up at that point after they have been approximated.

Now put on a loose flannel roller from hand to axilla, then a sufficiency of raw cotton, and finally plaster rollers, ignoring the traction strips and putting the bandages, cotton, etc., around or over them as if they did not exist. The assistants in the mean time keep up their pull on them in the line directed. In five minutes the plaster has hardened, following the irregularities of the arm and overlying padding, and the bones are fixed in the position desired. But what about these tenise straps that the assistants have been pulling on? Will

they not strangulate the circulation or produce sores? They might if left; but as they are covered with vaseline, by letting go one end there is no difficulty in pulling them out from beneath the plaster and leaving a small hole, which can be filled with plaster at once to make it neat. As soon as they are removed, split the plaster down in front and bring it together loosely with adhesive strips, for, unless it is so split, the surgeon will surely be called before midnight to do so, to relieve the tension due to the rapidly swelling elbow. I have repeatedly kept the splint on during the whole treatment with satisfactory results.

BLOOD EXAMINATIONS IN THEIR RELATION TO SURGICAL PROCEDURES.¹

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THE deductions which can be made in the comparatively new science of haematology are not yet many nor positive, in fact are often only inferences. It is our duty, however, to live up to the light we have, since far more mistakes in medicine are made from omitting to do so, than for lack of means of arriving at a correct solution of the problem. In especially three particulars much aid to the surgeon may be had by blood examination, viz., 1. Haemoglobin content; 2. Leucocyte decrease; 3. Leucocyte increase—polymorphonuclear, mononuclear; and to these three let me call special attention.

Haemoglobin percentage reduction occurs in various diseases, neoplasms, and conditions for which surgical interference is often the only remedy. In the last few years it has been clinically demonstrated that there is a limit beyond which it is almost always fatal to go, and as more and more evidence accumulates, this low limit is found to lie between 40 and 50 per cent. Below this the fatality of the immediate interference rises most emphatically, so that some good authorities refuse interference when below 30 per cent., unless instantly imperative. I have learned in this regard, however, that we must differentiate between a temporary sudden haemoglobinæmia and those forms of gradual diminution such as intestinal or stomach ulcers, haemorrhoids, uterine fibroids, or bleeding carcinomata may bring on. Take, for example, those induced by an extra-uterine haemorrhage. Here the haemoglobin content may sink to 18 or 20 per cent., and yet prompt, quick interference be

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well borne by the patient, since the blood-making capacity has not been impaired, overworked, or destroyed by preceding disease or losses; only a brief tiding over with transfusion, infusions, and stimulating enemata being necessary, while these identical efforts fail to restore those of the former class. There seems to be ground for the belief that the general anæsthetic is an important detrimental factor in the increased mortality, and the deduction is made that, where feasible, local anæsthesia (of Schleich) should be used. To those of us who see for the first time gall-bladders, herniæ, intestines, and bladder-stone operated on with the patient lying awake conversing with one, it will be a revelation as to the extent of interference thus made feasible.

Leucopænia.—Leucocytes decrease (from the normal 6500) with certain diseases, the number of which is quite limited (*e.g.*, malaria, tuberculosis, measles), and among which typhoid is the most often observed, we have a reduction far below the normal, of the white blood-corpuscles. Here, not infrequently, the blood examination will solve a difficult surgical problem. For example, I relate the following case:

A young man in previous fair health, but somewhat run down, is seized suddenly with a classical appendicitis of excessive violence, very high temperature (105° F.), is operated within fourteen hours from inception of attack. A badly gangrenous appendix removed not yet perforated. Temperature drops to normal and remains so nine days. Then a gradual rise during a week with all the ear-marks of a commencing typhoid: the proper curve, iliac tenderness, headache, Widal partial, etc. Repeated physical examinations by several able consultants failed to find any point at which it seemed probable suppuration could be, but the blood count revealed a leucocytosis of 19,000, with a predominance of multinuclear neutrophile corpuscles. This made it positive that it was not a typhoid, and, in desperation at inability to locate the focus, we explored the right lobe of liver, finding a centrally located abscess. Here without the blood count one could have been content to treat the case as one of typhoid. Again, the converse of this case may save

(if blood examination be made) some of the future typhoids from operation for suspected appendicitis when the tenderness is only that of the typhoid ileum! Such cases are recorded.

Certain drugs or starvation diet may reduce greatly the leucocyte count; hence, the blood findings are only to be considered as a single factor in the sum total which go to the making of a final diagnosis, and should never outweigh definite positive clinical knowledge. I recently removed an appendix from a patient whose blood count on three occasions was 4200, 4400, 4500, because all the classical symptoms were there, and only later discovered that the patient had been taking for a week enormous doses of a headache remedy with absolute starvation diet, water only.

Leucocytosis.—Again, the surgeon may gain valuable aid and information through those increases in the number of the white bodies of the blood now so often observed, provided a correct interpretation be made of their significance. Because we have not yet arrived at that ideal state, but make occasionally improper deductions, is no reason why we should deride or ignore those facts discovered by the painstaking work of others. The evidence is enormous and constantly accumulating which demonstrates the relationship between infectious inflammatory processes and the increase in the multinuclear neutrophile leucocytes. In like manner the number of mononuclear leucocytes in uncomplicated neoplasms is often observed. (Hartman.)

And while Donati's careful studies of the blood of thirty-seven cases of neoplasms show that there is no specific type of blood for neoplasms, they also show that the differential count shows changes in the number, form, and peculiarities of the cellular elements both red and white, that much information can be gained in uncomplicated cases. Growths breaking down in situations where at the same time they disturb the digestive processes, of course so complicate matters as to render the blood examinations only a secondary aid.

This brings us to the fact that there are two principal forms of white corpuscles, and that the number alone must not be depended on in doubtful cases, but the form and other pecu-

liarities must be noted if all the knowledge to be gleaned is to be utilized (Malassez). The multinuclear leucocyte is notoriously the one to wander out in the neighborhood of an infected area and, dead or dying, to constitute the pus formed. What wonder, then, that with increased demand there comes an increased production; the difficulty as yet being to differentiate between the physiological waves of increase and those produced by other factors than infection. Cabot's investigations make a 33 per cent. increase quite within the normal for such changes as digestion, exercise, and other physiological processes may induce. Indeed, the number of causes which may lead to a mild leucocyte increase are so numerous that only when associated with positive clinical evidences of disease should such increase have any influence in the ultimate decision.

Again, the absence of such increase should not outweigh clinical evidence sufficient to make a diagnosis, but may with justice influence prognosis and treatment.

In abdominal inflammations in particular can it be said that study of the changes in the blood has proven of most aid. For the year 1901, Woehnert calls attention to the fact that in those cases of appendicitis in which the white blood count ran above 20,000 pus was found. It is stated that in the non-suppurative variety of appendicitis over 20,000 count is not seen. It has been said that with this variety of infection more than any other intra-abdominal lesion is the leucocyte count highest and neutrophilic (Brown), perhaps because of the mixed type. When within twenty-four hours 18,000 are exceeded, one can usually be sure of a severe type of infection, and, with stationary or increasing severity of the clinical symptoms, operation will be justified. Again, with mild clinical symptoms but steady and rapid rise in the count the hint is furnished of progressing disease. In the later stages, a marked drop in a very high leucocyte count, without a corresponding improvement in the clinical symptoms, may be interpreted as increased severity in the condition, for, finally, the very toxins which in smaller amount call for the increase may in larger amount overwhelm the system producing leucocytes.

In intestinal obstruction, Cushing has emphasized the relationship of the leucocyte to the condition obtaining in the obstructed part. When in the first twelve hours without clinical symptoms being marked, if there be a rapid rise to 20,000 there is serious interference with the integrity of the incarcerated gut likely to terminate in (perhaps) gangrene. Schnitzler, too, emphasized this aid to decision as to operation; but there must be no way of schematizing, however, as all the clinical factors must be given their just weight.

In my limited experience, those causes inducing leucocytosis in the child do so to a higher degree and more quickly than in the adult. In conclusion, I would say with Biernacki, "It is as great a surgical sin to omit the examination of the blood in appropriate cases as failure in cases of general œdema to examine the urine." Hæmodiagnosis must in the future be a part, never the whole, of every carefully studied case, and if at times we are unable to interpret correctly these changes, we will be at others well rewarded for having not neglected this instrument of precision at our command, the blood counter of Zeiss or Breuer.

ON MYOSITIS OSSIFICANS TRAUMATICA.

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BONE may be formed in muscle or tendon under several distinct conditions. In the first place, there may be a process of ossification attacking one muscle after another, especially those of the trunk posteriorly, until the patient is in a truly pitiable state. The cause is totally unknown, but our profession has named the disease myositis ossificans progressiva, while the showman dubs the victim "the ossified man." I believe progressive ossifying myositis less uncommon than is usually supposed, as in the course of the present inquiry I have run across the tracks of several cases.

Another well-known condition in which bone forms in muscle or tendon is the result of slight traumata frequently repeated during a more or less extended period of time. Well-known examples of this condition are "rider's bone" in the origin of the adductors of the thigh; "cavalryman's bone," an osseous plate where the sabre hits the outer side of the thigh; "drill-bone" in the deltoid; "fencer's bone" in the brachialis anticus, due to repeated overextension of that muscle incident to the peculiar mode of fencing adopted by the German students in their duels.

Lastly, there is the so-called myositis ossificans traumatica, where a mass of bone forms in a muscle after a single injury. It is with this condition that the present paper has to do, and the subject may be introduced most easily by the recitation of an individual case.

G. O., aged forty-one years, seen by me September 19, 1902. Two weeks ago, while boxing in gymnasium, received a severe bruise on the right forearm and arm. Swelling and ecchymosis were marked, but soon disappeared under domestic remedies.

During the past two or three days has noticed a tumor in upper arm and pain on extending the elbow. On examination, one finds at the junction of the middle and lower thirds on the inner side of the right arm a tumor which passes down towards the elbow. The tumor is elongated, hard, size of a large thumb, movable from side to side, but not up and down; fairly tender. It is close to but not apparently intimately attached to the humerus, lies beneath the biceps, and is crossed by the brachial artery. There is no pulsation in the tumor, no radiating pain. Flexion of the elbow is normal; extension is slow and painful. There is no change in the sensibility, etc., of the hand. There is no elevation of temperature or acceleration of the pulse.

September 26, 1902. The tumor has increased slightly in size and disability is more marked. Chloroform; longitudinal incision over the tumor. Retracted biceps to outer side and the brachial vessels and nerves to inner, exposing a grizzly, hard, non-vascular tumor lying in the brachialis anticus muscle. The tumor was separated from its muscular bed by sharp and blunt dissection. At its upper end it was attached to the humerus, but the attachment was easily separated by a blunt periosteal elevator, leaving an area of humerus one inch square denuded of periosteum, but *not* rough. The corresponding surface of the tumor was rough. Along with the tumor a considerable amount of the brachialis anticus muscle was excised. The wound was closed with catgut and healed *per primam*. There has been no recurrence to date (March, 1903) and there is no disability.

The tumor is hard, measures two inches in length by five-eighths, by three-quarters of an inch. On longitudinal section it presents the gross appearance of a medullated bone with a narrow, red marrow cavity. The bone is not very hard, can be cut with a knife, but yet contains much gritty bone salts.

The following pathological report was made by Dr. Frank Hall, Professor of Pathology, Kansas City Medical College:

"For convenience of description we may divide the fusiform tumor into a proximal, middle, and distal part. The proximal portion forms a blunt cone, the middle a cylinder, and the distal a blunt cone. Immediately on removal, the tissue was fixed in a 4 per cent. solution of formaldehyde, decalcified in a 5 per cent. aqueous solution of nitric acid, rehardened in alcohol, embedded in celloidin, and cut into sections five micromillimetres thick.

Staining was accomplished with hæmatoxylin in combination with eosin or picrofuchsin. Instructive results were also obtained with methylene-blue and eosin. The cone-shaped proximal and distal portions of the tumor were sectioned parallel to the axis, yielding triangular sections; the middle portion was cut transversely, giving rectangular sections, one side presenting the muscular envelope of the tumor mass, the opposite side the ragged surface of the small central medullary canal. The proximal sections present for examination bundles of longitudinally cut voluntary muscles, intermuscular connective tissue, blood-vessels, and a small amount of fat. The muscle fibres are wavy, variable in diameter, and present very distinct longitudinal fibrillation with but faint transverse striations. The fibres generally react normally to eosin, but here and there one takes on a deep-red stain, either throughout its length or only in segments. These darker fibres or segments of fibres are seen, with the high power, to have lost both longitudinal and transverse striations and to be converted into homogeneous or finely granular masses. The sarcolemma of these affected fibres is more richly nucleated than normal, the nuclei being large, round, and sharply projecting. In a few instances a fibre or a portion of a fibre is represented by a thin granular mass enclosed in a shrunken sarcolemma.

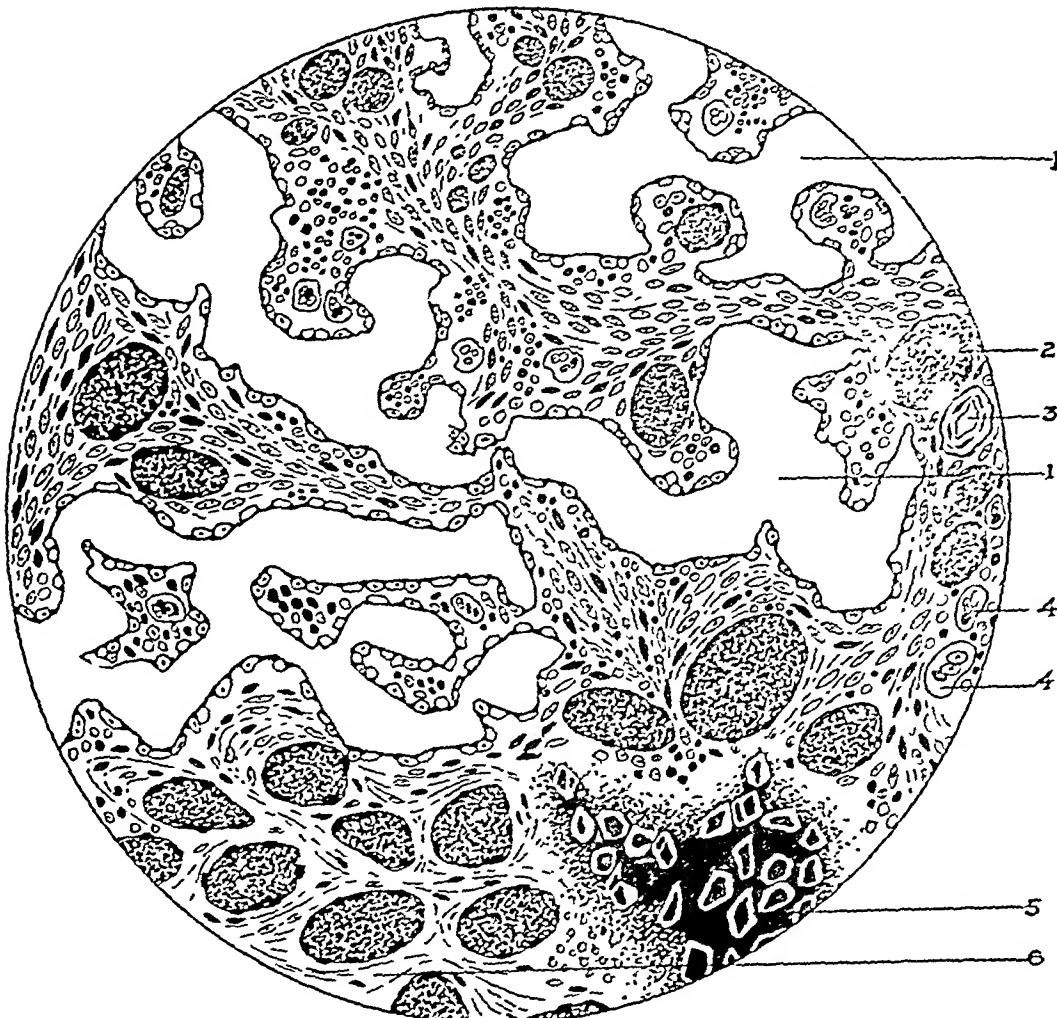
"The intermuscular connective tissue, composing the endomysium and perimysium, presents changes varying in quantity in different regions of the section. The perimysium is irregularly increased throughout, but more especially towards the base of the triangular sections, *i.e.*, towards the centre of the tumor. Changes in this connective tissue are recognizable by a loss of distinct fibrillation and by a failure to react normally to eosin, the color presented being a dark purple. The texture is in part massive, coarsely granular, in part thinly reticulated, the meshes occupied by a fine granular precipitate. The larger masses of connective tissue occur around the blood-vessels and increase in size, progressively, as the base of the section is approached. The nuclei are reduced in number, are either round or dash-shaped, and are darkly stained. At the base of the section the connective tissue suddenly broadens out like a fan, engulfing the muscle fibres and destroying most of them. This region presents a dense mass of tightly compact spindle cells with small linear nuclei. At the centre of the base of the section the density is broken by infil-

trating red blood-cells, large epithelial cells, and a few giant cells. The cells are the precursors of the ossified areas present in the centre of the tumor. The endomysium throughout the section is reduced to a thinly reticulated mass of fine fibrils, forming spaces filled with shadows of red blood-corpuscles and fine granular *débris*. The nuclei are free and lie scattered about in the reticulum. The blood-vessels throughout the apical region of the section are normal in number, engorged with corpuscles, and surrounded by an increased mass of connective tissue. Many of the vessels are apparently subjected to increased pressure, as is shown by their distorted lumina. The fatty mass at the apex of the section presents nothing abnormal, save that its connective tissue is of the same character as that found elsewhere in the section.

"The sections cut from the middle portion of the tumor present the processes exemplified by this material in full blossom. Externally, masses of muscle fibres in cross-section present for inspection. Here we find many dark, red-stained fibres interspersed with normal ones, as noted in the proximal sections. Approaching the centre of the section, the intermuscular connective tissue becomes progressively broadened and thickened with more and more abundant linear nuclei and fewer and fewer blood-vessels. No possible line of demarcation can be detected between the muscular envelope and the osseous centre. Spicules of bone and islands of cartilage arise amidst the masses of intermuscular connective tissue. In many places connective tissue is transformed directly into bone; in other areas the connective-tissue cells seem to surround themselves with a capsule and gradually form about themselves the characteristic homogeneous, blue-staining cartilage matrix. As we approach the centre of the tumor the bony trabeculae developing about and between the muscular fibres push them farther apart, destroying some of them, enclosing others in a tight embrace. The enclosed fibres of muscle vary much in diameter. Some are much larger than normal; others are reduced to little more than pink dots. In some of the fibres one finds, under the high power, several nuclei; in others the centre is vacuolated or reduced to amorphous granules. In many instances the sarcolemma is penetrated by red blood-cells, thus forming a sheath about the sarcous substance. In a few instances the red cells even penetrate into the centres of the fibres.

Strangely enough, a few muscle fibres in a fair state of preservation persist in the very centre of the tumor. On close inspection the new formed bone is seen to be fairly perfectly formed. Each trabecula is clothed in a thick tunic of cubical osteoblasts which come to lie enclosed in lacunæ as the process of ossification advances. The islands of cartilage begin to ossify at their periphery.

FIG. I.



1, Bone trabecula; 2, cross-section of voluntary muscle fibre; 3, cross-section of blood-vessel; 4, multinuclear giant cell; 5, area of cartilage; 6, intermuscular connective tissue.
(Drawn by Dr. Frank Hall.)

The forming bone reacts to eosin; thus the bony trabeculæ and borders of the cartilage areas are of varying shades of pink. Marrow spaces are abundant and are occupied by a perfect chaos of spindle cells, red blood-cells, muscle fibres, and multinucleated giant cells. Plasma cells are present, but not abundant. The

blood-vessels of the marrow are remarkably few and imperfectly formed. Erythrocytes evenly infiltrate every available space in the marrow. In the centre of the growth are several blood cysts of varying sizes. Some contain well-preserved erythrocytes; others are occupied by a reticulated mass of fine fibrils and amorphous granules.

"The distal portion of the tumor resembles the proximal in every respect. The intermuscular tissues are somewhat more abundant and grade to the normal more gradually. Certain deeply-pigmented cells are scattered in the stroma. These are doubtless wandering cells which have taken up coarse-brown granules of blood pigment."

A number of explanations have been forthcoming as to the origin of intramuscular masses of bone after trauma, and each of the explanations has been subjected to keen criticism.

1. One of the earliest theories expounded was that, as a result of the injury, blood was effused, and this blood became transformed into bone. This theory might have passed muster in the days when it was believed that tissues were regenerated by the direct metamorphosis of blood-corpuscles into connective tissue.

2. The second theory demanding attention is one of great importance and is undoubtedly correct in many cases. It accuses the periosteum of being the "*fons et origo mali*." Osteomata may arise from the periosteum in several ways:

(a) A severe blow is inflicted. The muscle affected is crushed into a pulp. There is injury to a limited and adjacent area of periosteum. The cells of the injured periosteum proliferate, escape into the pulpy area of muscle, and there develop. A mass of bone is formed which may have only a loose connection with the periosteum or may become entirely detached from it.—(F. Berndt.)

(b) A muscle is in action, receives a blow; some of its fibres tear themselves loose from their bony origin and, retracting into the mass of muscle still connected with the bone, carry with them particles of periosteum. These particles of periosteum grow in their new environments, are true bone grafts,

and can form intramuscular osteomata, unconnected with, though originating from, the periosteum.—(Boppe, Demmler, quoted by C. Lyot, *Traité de Chirurgie*. Le Dentu et Delbet, iv, 776.)

Berthier, to prove this theory, detached in rabbits with a knife little flaps of periosteum, and by electrical stimulation of the muscles he succeeded in having these flaps pulled away from the bones, and in time found that where they were there developed little nodes, first of cartilage, then of bone. Delorme was never able to detach periosteum from bone by any force applied to the adductors of the thigh in the cadaver.

(c) As a result of one trauma, a regular flap of periosteum is detached from the bone in whole or in part, and being drawn into the belly of a muscle develops there, forming an osteoma. It is said that a bone cyst may be formed in the above manner.

F. Schulz writes (*Beiträge zur klinischen Chirurgie*, Band xxxiii, 541): One must assume that a flap of periosteum was torn entirely free from the femur (he is speaking of a definite case), that this became separated from the bone by blood and fragments of contused and lacerated tissue. The separated flap of periosteum reacts normally to the stimulus of injury by proliferation and ossification; thus a plate of bone is formed separated from the femur by the blood and detritus referred to. But the wounded periosteum surrounding the bone left bare by the detachment of the periosteal flap also reacts to the injury and forms bone, and this new bone meets and fuses with the bone formed in the aforesaid flap; thus a complete bony wall is formed around the blood and detritus and the cyst formation is complete. This notion of Schulz's by no means explains the occurrence of cysts unconnected with the bone; such might possibly arise from the separated fragment of periosteum becoming rolled up in the shape of a capsule around a blood-clot or collection of detritus. If this rolling up occurred and the periosteal cells proliferated and ossified, then, presumably, a blood cyst might be formed.

3. A third theory, that of Cahen, involves the adoption of

the famous Cohnheim theory of the origin of tumors. Cahen considers the osteoma primarily muscular and, when connected with a bone, this connection entirely secondary. He assumes that there have been present in the muscle aberrant masses of embryonic material originally provided for the development of the normal bone, but unused; they have lain in the muscle until stimulated to growth by the trauma. Undoubtedly foetal remnants of various kinds are scattered in various parts of the body—*e.g.*, remnants of the branchial clefts in the neck and of the primitive suprarenal body in the kidney—and as undoubtedly, when subjected to the proper stimulus, these develop into more or less complicated epithelial tumors and cysts in the neck and into hypernephromata in the kidney; so that we are compelled to admit the entire possibility of Cahen's assumption. The probability of the assumption is another matter, and, as there are other and simpler explanations of the condition, one need only bear in mind that such an origin is within the range of possibility, but is so very improbable that it need not be considered with much seriousness.

4. Ziegler assumes that in patients the subjects of myositis ossificans, whether traumatic or progressive, there is a congenital diathesis of the connective tissue of the muscles, fascia, tendons, ligaments, etc., in that they become endowed with powers normally belonging to the periosteum alone. This theory is closely related to the Reichert notion of the connective tissues. Reichert considers that all those tissues which are composed of cells lying in an intermediary or ground substance (bone, cartilage, connective tissue, etc.) are morphological equivalents, each capable, under suitable conditions, of replacing the others. As Pierre Delbet says, "The development of osteomata separate from the skeleton is a powerful argument in favor of Reichert's theory." In the case of progressive myositis ossificans the assumption of Ziegler or the theory of Reichert must be accepted either *in toto* or in some modified form; here there can be no question of periosteal origin; the condition seems to be one of proliferation and metamorphosis of the intramuscular connective tissue. When the so-called

myositis ossificans is limited to one muscle and is the result of a single trauma, there can be little or no doubt that the ossification may proceed from the injured—*i.e.*, the stimulated—periosteum; but that it does so in all cases is hard to believe. Observers have differed in their opinions as to whether the process under consideration is a tumor or an inflammation. Grawitz and Salmon, under Bergmann's auspices (quoted by Rothschild), investigated this matter and, basing their opinion on clinical and microscopical evidence, pronounced the disease inflammatory. Clinically, they found that the temperature was frequently elevated in the early stages, and that the acuteness, the amount of swelling, and the tenderness of the affected muscles all indicated inflammation, while microscopically there was early cloudiness, later degeneration of the muscular fibres; small-cell infiltration of the connective tissues around the altered parenchyma; the presence and enlargement of blood-vessels in the neighborhood. Virchow and most of the older writers think the disease belongs to the border-land between inflammation and tumor, while later pathologists, as Ziegler, Birch-Hirschfeld, and others, lean towards the tumor hypothesis.

It will be noticed that in my case ossification is as far advanced in the distal as in the proximal portions, that around and throughout the tumor there is great proliferation of the intramuscular connective tissue, that ossification is both of the fibrous and cartilaginous type, and that muscle fibres in every stage of degeneration are scattered here, there, and everywhere, lying in the connective tissue, in among the islands of cartilage, and hugged by the trabeculae of bone. There is no microscopical evidence of any inflammatory changes. If this case is one of purely periosteal origin, then the scattering of the periosteal cells or grafts must have been through a territory extraordinary in length and in latitude wonderfully limited. Its origin from a separated periosteal flap is simply inconceivable in view of its relations to the innumerable discreet and degenerating muscular fibres. From careful examination of

even this one case, one is forced to admit the possibility and probability of the bone tumor being the result of proliferation and metamorphosis of the intramuscular connective tissue.

Rothschild's first case supports this view. The tumor developed in six weeks in the brachialis anticus and required removal from the humerus by the chisel. The surface of the humerus at the point where the tumor had been attached was so rough that it gave the impression that a portion of the superficial layers of the bone had been removed with the tumor. Really this roughness was due to a deposit on the bone, which, when removed with the chisel, showed intact periosteum under.

The following cases, most of which were kindly communicated to me by the surgeons in charge, seem to substantiate the muscular origin of the tumors under consideration:

RIXFORD, E. (San Francisco). H. H. C., physician, aged sixty-five years, operated April 15, 1902, for pyloric obstruction. Median incision beginning at the xiphoid was made, and the sheaths of both rectus muscles opened. The operation on the pylorus had to be abandoned, and a simple posterior gastro-enterostomy was done with a Murphy button. Abdominal wall closed in layers with catgut. Recovery rapid. On the seventh day the wound appeared to have healed by primary union. On the tenth day a few cubic centimetres of pus were found at the upper end of the incision. The small cavity was packed with lint saturated in turpentine and oil and rapidly closed. The patient rapidly gained in flesh and strength, and had no discomfort until August, when he had a sharp pain in the cicatrix when he made certain movements. He discovered a small hard mass in the left rectus. In November the bone was about five centimetres long and one centimetre wide. It was *not* attached to the xiphoid, but reached very near it, and was in the edge of the muscle.

February 11, 1903. The bone tumor now measures three inches in length and three-quarters of an inch in width and is separated from the xiphoid by nearly one-half an inch. It causes no discomfort except when the patient bends forward, and then the sharp ends of the bone prick.

MACDONALD, W. G. (Albany, N. Y.). Manufacturer, aged fifty years, who some twenty years previously had received an injury to his chest as the result of an explosion. There was considerable destruction of the skin, and subsequently numerous areas of deposit of bone in the pectoralis major. My best recollection is that there were several areas extirpated, and that the disease first made its appearance distinctly some six or eight years after the primary injury.

MARKS, S. (Milwaukee, Wis.). On the eve of battle I was consulted by a soldier for not only bowel trouble, but for what he called a hard lump located about the middle of the left sartorius muscle. He informed me that it was the result of a blow received some five or six years previously, which made him lame for some time. He said, however, that he was entirely well at the time of enlistment. I regarded it as bony matter. If my memory serves me, he was wounded the next day but one after my examination and died soon after. I procured the specimen, which was about one-eighth of an inch thick and slightly oval and about one inch in length, but in the hurry of movements I lost not only that but many other valuable specimens.

GASTON, J. McFADDEN (Atlanta, Ga.). W. H. E., aged sixty years; old double hydrocele. Injection of Lugol's solution. He presented symptoms of inflammation altogether disproportionate to the treatment given. By incision there was removed pus, disintegrated tissues, and then an osseous formation; recovery. There was absolutely no mistaking the bony mass, which was about the size of a walnut. The existence of this was traceable to an injury to the testicles and the muscles years before.

ELLIOT, J. W. (Boston, Mass.), through the courtesy of Dr. H. B Howard. E. H., aged thirty-six years, admitted to the Massachusetts General Hospital May 20, 1902. In February, 1902, while working, a box weighing 400 pounds fell on his right leg; skin on the outside of the thigh was scratched and the leg rapidly became swollen. Pained him considerably, and he stopped work for a week on account of stiffness. Then he returned to work for four weeks; he found then it was very painful to go up and down stairs, so he had to give up work, and has not worked since. Pain is just above the joint and feels as if a knife were run into it. Swelling of the leg was reduced with poultices, but of late is becoming hard and appears to be growing larger down towards the joint. On May 31 an incision was made just outside of the vastus externus down onto the tumor. This consisted of a mass of soft spongy bone laid on over the femur and was chiselled off, leaving the shaft and periosteum apparently intact. No sarcoma was found by the microscope. Result: relieved.

F. MUNRO (Middlesborough, Eng., *Lancet*, Vol. i, 1891, p. 427). T. A., aged twenty-four years. May 15, 1890. Playing at football on Easter Wednesday, received a blow from another player's knee in front of right thigh. One week afterwards noticed hard swelling one and a half inches above the outer side of the knee. On examination five weeks after injury "there was found what seemed to be a lump of bone lying loose in the muscles of the outer side of the thigh. It was about eight inches long, narrow, and projecting at its lower end and approaching the surface, but broadening out as it passed up the thigh and lying more in the muscles. It was slightly movable except at its upper end."

June 1. *Operation.*—The mass lay in the substance of the vastus externus, being separated from the femur by a sheet of fibres. The mass was a slightly curved plate about eight inches long, arising from the

origin of the vastus and the linea aspera. It was fully a quarter of an inch thick at its origin, thinning as it passed outward and downward. Professor Greenfield, of Edinburgh, examined the specimen and pronounced it typical myositis ossificans, differing from Orlow's case, which he cites, in not being so vascular and not containing cartilage. Orlow's case (*Virchow's Annual*, 1889) was one of medullated, dark-red bone, without any distinct cortical substance, lying in the upper end of adductor longus muscle, and seen five months after injury was sustained. Orlow believed both periosteum and intermuscular connective tissue took part in the formation of the bone.

VULPIUS (Heidelberg, *Verhandlungen der Deutschen Gesellschaft für Chirurgie*, 1902). J. Z., aged twenty-one years, male, fell on an iron bar, hitting the left thigh. Pain; worked for three weeks. Condition got much worse almost in one night. Could not bend the knee; thigh tender and swollen. On examination, four weeks after injury, there was found distinct swelling of the flexor aspect of the thigh, midway between "spina" and patella. Skin unaltered; tumor long, firm; its centre of bony hardness; not tender; movable on the femur with slight crepitation. The knee can be fully extended both actively and passively, but power is decreased. Flexion is possible to 150 degrees, but then firm obstruction is encountered.

Operation.—Incision at the outer edge of the tumor, which was found surrounded by firm, tendon-like connective tissue. In several places indurations penetrated farther into the muscle, and in the centre of these indurations there were bony, hard bodies. Blunt dissection was impossible because of close union with the muscle. The tumor was a cyst surrounded by a complete shell of bone varying in thickness. The cyst was removed in two pieces, as also the neighboring indurations. Neither the femur nor its periosteum was exposed or injured. The tumor on its femoral side was covered by a large layer of degenerated muscle. The cyst was twelve centimetres long, three to four centimetres high, and two to two and a half centimetres wide. The circumference was ten to eleven centimetres. At places the bone was translucent; at others it was two millimetres thick; its cavity was lined with uniform, glistening, bluish membrane which sent septa from one part of the walls to another. The contents of the cyst were extravasated blood.

BERNAYS (St. Louis). Miner, aged forty-five years, from Colorado, had received numerous bumps from an ore-box or basket hitting him just above the knee of the right side. There was a tumor as large as half a small cantaloupe in the quadriceps, which felt hard in spots, of indefinite origin as to time, and slow growth. Extirpation showed an osteoma in the vastus internus extending into the externus, which contained cyst-like cavities filled with mucoid jelly. This was clearly a muscular osteoma and had no connection with the bone or periosteum, unless the attachment of the muscles to the patella are considered, and the tumor was fully four inches above the patella. Extirpation; primary union; no loss of function.

While this case of Bernays's seems to have followed repeated traumata, yet it is so distinctly an example of traumatic myositis without periosteal involvement that it is included here.

Schüler, Heinrich (*Beiträge zur klinischen Chirurgie*, Band xxxiii, 556), in his excellent "arbeit" based on von Braun's material, admits fully the existence of myositis ossificans traumatica, although his paper is concerned with the very similar condition known as traumatic exostoses. He writes. "Such traumatic bone tumors appear to be very rare, much rarer than traumatic bony neoplasms in the muscles, and we have failed to find any such case in literature since Housell's publication (from the same clinic)."

In all the cases reported by Schüler there was a single trauma; in no case was there evidence of a haematoma. The tumors only became noticeable after weeks. The immediate swelling was always slight. In one case the arrangement of tendon tissue on the fragment removed showed that the fragment must have been the point of insertion of the tendon, and that at the moment of injury the tendon pulled off a portion of periosteum with fragments of bone attached. In all the cases periosteum covered the tumors and was firmly united to them, though here and there it showed pathological thickenings. *The musculature was never in any structural relation with the tumors.* The muscle lay on the surface and could be separated by blunt dissection.

It will be seen that there is a very sharp distinction existing between the cases reported by Schüler under the title "traumatic exostoses" and such cases as that reported by me. Undoubtedly many of the cases classed as "myositis ossificans" are truly exostoses, and one might well consider all cases which are of purely periosteal origin to be such, but the difficulty or impossibility of clinically separating the tumors of one origin from those of the other makes it convenient to class them together, and then, to avoid the introduction of theories into nomenclature, we might label such cases "traumatic osteomata" connected or unconnected with the skeleton, as the case may be.

Sometimes, instead of one muscle being the seat of an

osteoma, one whole group of muscles is affected. Bernays (St. Louis) sent me the following report of a boy, aged ten years and of excellent family history:

"Tumor of most peculiar shape. The entire flexor group of muscles arising from the internal condyle of the humerus seemed to be enlarged, swollen, and hardened. Palpation detected hard, spicula-like pieces of bone in the tumor mass. These were only found in the muscular bellies of the flexors. I thought it to be a malignant tumor and advised extirpation, probably to be followed by an amputation. I removed the mass, leaving a sadly mutilated forearm. . . . Primary union. Microscopical examination (and in fact macroscopically I thought the tumor non-malignant) proved it to be a lipoma intramuscularis angiomatodes ossificans. There were irregular, branched, and sponge-like osteomata in four of the muscle bellies. Function now, three or four years after operation, is remarkable, although only the supinator longus was left. The small muscles of the hand have developed immensely. . . ."

In progressive myositis ossificans the process affects fasciæ and tendons as well as muscles. Rothschild has only seen one case where, as a result of trauma, there was isolated ossification of tendon, and he has found no reports of such cases, although, as he points out, ossification of tendon is the same in principle as that of muscle, where the process takes place in the intra-muscular fibrous tissue.

Rothschild's case. P. K., aged forty-five years. December 20, 1899, heavy coal-wagon went over his left foot. In hospital ten weeks. At the end of this time there was severe pain running from the tendo Achillis round both malleoli to the dorsum of the foot. The patient was unable to walk.

March 3, 1900. Temperature and pulse normal; left leg from the middle of the foot to above the malleoli œdematosus; contour of ankle lost; motion in talocrural and talocalcaneonavicular joints normal. Left tendo Achillis was neither visible nor palpable in any position, but in its place is a broad, bony, hard mass springing from the calcaneum, corresponding to the tendo Achillis, reaching to three finger-breadths above the tuberosity of the os calcis and apparently losing itself in the flexor muscles. The right and left margins of the growth are well defined. œdema rapidly increases on walking. Skiagram shows a spur of bone corresponding to the tendo Achillis.

12th. Operation by Professor Rehn. Most of the tendon has been replaced by an immobile mass of bone lying in tendon tissue. The tumor was separated from the os calcis by a chisel, from remnants of tendon by sharp dissection; recovery.



FIG 2.—Skiagram of Dr J. M. T Finney's case of osteoma in tendo Achillis.

Microscopical examination shows connective tissue becoming metamorphosed into cartilage. The long spindle cells become gradually thicker and rounder, surround themselves with a capsule, and inclose a vesicular nucleus until they become true cartilage cells. The cartilage may be seen changing into bone. The cells first lose their capsule, become smaller and thinner, and the intercellular substance becomes denser and opaque.

FINNEY, J. M. T. (Baltimore), has reported to me a case very similar to the above, although the history of an individual injury is not so definite. "The patient was a minister, about fifty years old, who had noticed, following the use of a new, rather tight shoe, a tenderness along the right tendo Achillis. This continued to bother him for some months, until finally he consulted me as to the cause of his trouble. I found a thickened tendo Achillis with external evidence of injury from the top of the shoe in the nature of callus formation, and on examining the tendo Achillis found a hard substance that felt very much like bone. It was about one and one-half inches long by one-half inch in thickness. I had an X-ray taken of both feet, and this showed that the hard substance I felt was true bone, while on the opposite side there was no evidence of bone formation whatever. The patient assured me that the two tendons were alike before the injury spoken of, and that he had noticed himself the formation of this bone in the tendon. I have not seen him for about eight months, but at the end of that time the bone formation had progressed perceptibly since my first examination. I am not quite sure whether the bone was confined entirely to the tendon or whether or not it had involved to a certain extent the lower portion of the muscle, since I did not operate."

Statistics.—For the sake of convenience, I will place all the cases of traumatic osteomata, whether connected or unconnected with the skeleton, in one group, indicating by a double asterisk those considered by the authors themselves to be traumatic exostoses. Although I have verified most of the references given in Rothschild's and Vulpius's lists, yet it will be convenient to omit the numerous individual references. The cases marked by a single asterisk have been reported to me by personal communication. I desire to take this opportunity of expressing my sincere thanks to the numerous colleagues, both in America and Europe, who have, at the expense of time and trouble, most kindly and courteously aided me in the preparation of this paper. Especially are my thanks due to my friend, Dr. Frank Hall, for the beautiful preparations and drawing he has made from my specimens.

Dr. Otto Rothschild. "Ueber Myositis ossificans traumatica."
(*Beiträge zur klinischen Chirurgie*, 1900, Band xxviii, 1.)

1816. Otto,	Diaphragm	I
1854. Schuh,	Vastus ext.....	I
1856. Rokitansky,	Biceps	I
1863. v. Pitka,	{ a. Brach. int.....	I
	b. Both brach. int.....	2
Barth,	Rect. fem.....	I
Sangalli,	Digastric	I
1873. Podratzky,	Brach. ant.....	I
Billroth,	Biceps	I
Ebstein,	Ileopsoas.....	I
Busch,	Psoas.....	I
Konetschke,	Gluteus max.....	I
Weinlechner,	Ant. of thigh.....	I
Meinhold,	Quadriceps.....	I
Rasmussen,	Brach. ant.....	2
Cahen,	{ Vastus ext.....	I
	Quadriceps	2
	Brach. ant.....	I
Salman,	Ileopsoas [Trauma?].	
Ruthke,	Ant. of thigh.....	I
Bremig,	{ Shoulder.....	I
	Vastus int.....	I
	Vastus med. and ext.....	I
Rothschild,	{ Brach. ant.....	I
	Tendo Achillis.....	I

Dr. Oscar Vulpius (Heidelberg). "Zur Kenntniss der intra-musculären Knochenbildung nach Trauma."

(*Verhandlungen der Deutschen Gesellschaft für Chirurgie*, 1902, Vol. ii, p. 127.)

Grunbaum	2
Elbogian.....	3
Schnitz.....	7
Sudeck	I
Regnier, Brach. ant.....	2
Zhoher and Okioz	2
Zimmerman.....	I

Dr. Rammstedt (Halle). (*Archiv für klinischen Chirurgie*, Vol. lxi, p. 153.)

Martin,	Vastus int.....	I
Rammstedt,	Vastus int.....	2

Dr. Berndt. (*Archiv für klinischen Chirurgie*, Vol. lxv, p. 2.)

In muscles outer side thigh.....	3
(Two were in same patient from separate kicks.)	

Dr. O. Wolter. "Ueber Myositis ossificans traumatica mit Bildung von Lymphcysten." (*Deutsche Zeitschrift für Chirurgie*, Vol. Ixiv, p. 318. Ref. *Centralblatt für Chirurgie*, December 6, 1902.)

Extensor of thigh.....	2
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Dr. Graf. "Zur Casuistik der traumatischen Ossificerenden Myositis."

(*Archiv für klinischen Chirurgie*, Vol. lxvi, p. 1105.)

Adductor magnus.....	I
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W. Mysch. (*Deutsche Zeitschrift für Chirurgie*, Vol. liv, p. 207. Ref. *Centralblatt für Chirurgie*, August 4, 1900.)

Brach. anticus.....	I
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Hoffmann. (*Deutsche militärarztliche Zeitschrift*, 1902, No. 4. Ref. *Centralblatt für Chirurgie*, 1902, No. 37.)

Brachialis anticus.....	2
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Dr. F. Schulz (Rostock). (*Beiträge zur klinischen Chirurgie*, Vol. xxxiii, p. 541.)

** Schulz, Quadriceps.....	1
** Housell, Outer side thigh.....	2

Dr. Heinrich Schüler (Tübingen). (*Beiträge zur klinischen Chirurgie*, Vol. xxxiii, p. 556.)

** Deltoid.....	1
** Anterior of thigh.....	1
** Upper half femur.....	1

F. Munro. (*Lancet*, 1891, Vol. i, p. 427.)

Vastus externus.....	1
Orlow. Adductor longus.....	1

J. Hutchinson, Jr. (*Transactions Clinical Society*, London, 1898-99, Vol. xxxii, p. 230.)

Brachialis anticus.....	1
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F. Eve. (*Transactions Clinical Society*, London, Vol. xxxii, p. 232.)

Crureus and vasti.....	1
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C. Lyot. (*Traité de Chir. Clin. et Op. Le Dentu et Dellet.*)

Demmler Triceps cruralis.....	1
Orion.....	1
* W. J. Taylor, Philadelphia. Ant. thigh.....	1
* J. C. Oliver, Cincinnati. Triceps tendon.....	1
* W. G. Macdonald, Albany. { Pectoralis major.....	1
	1
* J. M. T. Finney, Baltimore. Tendo Achillis.....	1
* S. Marks, Milwaukee. Sartorius.....	1
* McF. Gaston, Atlanta. Cremaster.....	1
* R. Matas, New Orleans. Adductor longus.....	1
* E. Rixford, San Francisco. Rectus abdominalis.....	1
* F. E. Banks, Cleveland. Upper arm (seen very casually).....	1
* S. H. Weeks, Portland, Me. Pectoralis major.....	1
	1
* A. C. Bernays, St. Louis. { Flexors forearm.....	1
	1
	1
* By courtesy of Dr. H. B. Howard, Massachusetts General Hospital: Service of Dr. Harrington. Vastus ext.....	1
Service of J. W. Elliot. Outer side upper third thigh.....	1
Case reported by the writer. Brach. ant.....	1

Total number of cases..... 86

WEEKS, S. H. (Portland, Me.). Man, thirty to thirty-five years of age. Right hand and forearm caught between heavy cross rollers, which resulted in crushing the soft parts and breaking the humerus in two or three places. The fractures united, the soft parts healed, and he has a useful arm. The attending physician found a hard mass in the lower border of the pectoralis major between two and three inches from its insertion into the humerus. On examination, Weeks found in the free border of the muscle as it crosses the axilla a hard mass as large as a walnut, as dense and hard as bone. Diagnosis, myositis ossificans traumatica. Weeks only saw the case once.

HARRINGTON, F. B. (by courtesy of H. B. Howard, Boston). E. T. M., aged thirty-eight years, sailor. July 23, 1901.

Past History.—Good until fifteen months ago. Gonorrhœa; no pox; tabes for past fifteen months; worse of late; lightning pains; partial blindness in right eye.

Present History.—Five weeks ago wrenched thigh; ecchymosis from knee to hip. When swelling of thigh went down he noticed a hard tumor attached to the femur high up; moves on moving leg; cannot walk without pain, nor can he walk in a dark room. Tumor has increased slowly in size.

Present Examination. . . . —Hard, nodular, irregularly rounded mass immovably attached to and on outer side of upper third of femur on the right side. Felt above Poupart's ligament. Does not fluctuate. No tenderness.

Operation, July 27.—Incision three inches long made over prominent part of tumor on front of thigh just above level of the trochanter. Small piece of tumor chiselled out. Tumor apparently developing in muscle sheath. Resembled normal cancellated bone.

TAYLOR, WILLIAM J. (Philadelphia). Man, aged twenty-three years; vigorous health; no rheumatic or specific history; is a horseman. On December 15, 1900, he was kicked by a horse on the anterior portion of the left thigh about the middle. The blow was severe, but, on being assisted onto his horse, he rode home. Intense pain; has ridden constantly since, though latterly insecure in his seat while riding a restless horse, as he could not hold on with his knees without pain. When seen, January 5, 1901, three weeks after trauma, there was marked swelling on anterior of thigh, over which the muscles rolled easily, but did not give a sense of a solid tumor, rather of an organized haematoma deep under the muscles. No pain except on certain movements, principally flexion of the knee.

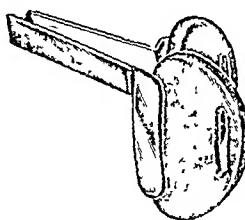
Operation, January 8.—Incision. Swelling quite hard. The periosteum was broken down with quite a blood-clot beneath it, and certain of the muscles had apparently undergone degeneration, in which there were a number of small, hard masses resembling bone. The pathologist reported that the degenerative and necrotic changes going on in the muscles associated with the presence of newly-formed bone in the connective tissue led him to suspect that it was a myositis with a tendency towards the formation of new bone. No evidence of malignancy.

BRIDGE FOR TREATMENT OF NASAL FRACTURES AND DEFORMITIES.

BY W. W. GRANT, M.D.,
OF DENVER, COLORADO.

THE little instrument I now describe and illustrate is a nose bridge devised for use in the treatment of fracture of the nose and also depression and deformity from disease of septum. The use of plugs of cork, metal, rubber, or any other material to support the parts and prevent deformity, is not satisfactory,

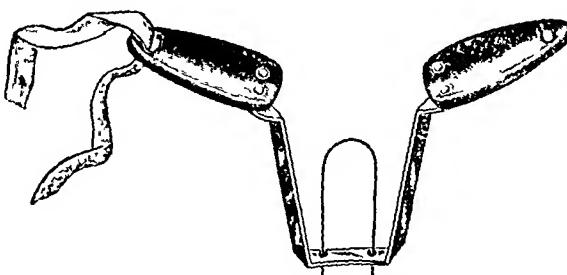
FIG. 1.



[Side view

either as to cleanliness or in preventing deformity. Success depends, in a measure, in keeping the nose clean during the healing process, and, though the plug should be removed daily for the purpose, it is not cleanly. But the use of this bridge

FIG. 2.



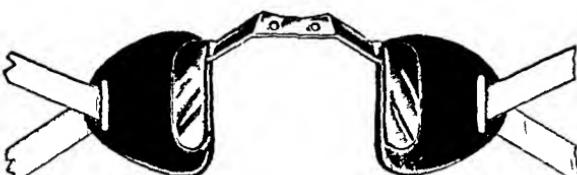
View from above.

does not prevent or interfere with the use of the plug, if one desires, in addition; and it can be more safely removed for either inspection or cleanliness. But its use can be wholly dispensed with, though it might in some cases be of use, for a

few days, to prevent lateral deformity. If a plug should be used, it ought to be hollow and have lateral perforations for purposes of drainage, spraying, and breathing.

The instrument is composed of two cheek-plates of hard rubber not exceeding one-eighth inch in thickness, and should be one and one-half inches in greatest diameters, cheek surface

FIG. 3.

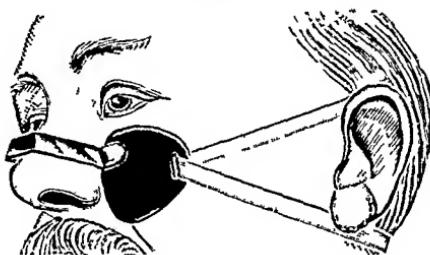


Front view.

slightly concave; two upright steel bars one and one-half inches long, one-third inch wide, a connecting bar three-fourths inch long, and a double tape twelve inches long to fit in the slot of the rubber plates.

In acute cases the instrument is applied as follows: Take a needle, preferably a straight one, with a stout silver wire; insert the needle from outside of nose, close to the septum at or near the point of depression; enter the cavity and push the needle out of the anterior naris. Now thread with a curved

FIG. 4.



Instrument applied.

needle, re-enter the nostril, same side, and carry the needle through the septum. Bring the needle out of the opposite nostril, re-enter meatus, and carry the needle through the skin from within out close to the septum and directly opposite the primary entrance. The septum is now embraced in a loop.

The bridge is now applied by straddling the nose and tying the double tape (all in one knot), moderately tight, back of the head, one piece being placed above and one below each ear. The ends of the wire are now carried through the little holes in the transverse bar of the instrument, the septum pulled upward to a satisfactory position, and the wire twisted around the bar.

In chronic cases, whether the deformity is the result of injury or destruction of the septum from sloughing, it is, of course, necessary to operate before applying the retentive apparatus. The division of the septum may be made through the nares, or, better, by making a short incision from without at the upper part of the depression, entering the cavity through this opening and dividing the septum with scissors downward nearly to the floor of the nose, and then by a curved incision forward to near the tip of the nose, but not completely severing the septum at this point, which will act as a hinge. The septum can now be elevated and is ready for the wire. The nose incision may be used for carrying the wire through the septum, but not for the suspension. The incision should be closed at once by a subcuticular stitch. The suspending force should be confined to the septum; therefore it is not best to put needle and wire through the nose from side to side. If it is necessary to divide the bony septum, this may be done with the nasal saw. If granulation tissue should not close the space due to elevation of cartilage, it may be effected by a mucous flap at a subsequent date.

This bridge will fit the cheek of the average adult quite accurately. It sets firmly and is not easily displaced. A smaller size is better for children. It is simple, easily applied, inexpensive, and will answer the purpose better than any instrument or method now in use. It may be obtained from Truax & Green, of Chicago.

TRANSACTIONS
OF THE
NEW YORK SURGICAL SOCIETY.

Stated Meeting, April 22, 1903.

The President, LUCIUS W. HOTCHKISS, M.D., in the Chair.

THE CHEMISTRY OF THE BLOOD IN CANCER; A NEW
HYPOTHESIS FOR THE ETIOLOGY.

DR. JOHN ROGERS read a paper with this title, for which see page 280.

DR. CHARLES G. L. WOLF dwelt upon the exceeding difficulty of the line of investigation undertaken by Dr. Rogers, and the perseverance that had been shown in the work thus far. The entire question of the carbohydrates in the blood, even under physiological conditions, was still unsettled,—the necessary analyses being exceedingly difficult and the results oftentimes unsatisfactory. When one bore in mind that Dr. Rogers was working upon operative cases, where even the collection of the blood was no easy matter, the obstacles surrounding the problem were more readily appreciated. The line of research was exceedingly suggestive, and the speaker said he felt certain that results would be obtained therefrom.

DR. WILLY MEYER said he recalled one case of carcinoma of the breast in a woman with far advanced diabetes. The family insisted on surgical interference on account of the great pain the patient had to suffer. Radical operation was done, and the patient died of diabetic coma forty-eight hours after the operation.

DR. ROGERS said that in reviewing the literature of the subject he found that apparently the only disease which was incom-

pative with cancer was diabetes. Among thousands of cases of diabetes, including those in the St. George Hospital Reports, he had only come across a single exception to this rule, and that was a case of cancer of the pancreas found at autopsy. The speaker said that while cancer no doubt developed in diabetic patients, that occurrence was extremely rare.

CARCINOMA OF THE BLADDER; COMPLETE EXTIRPATION OF THE BLADDER; RECTAL IMPLANTATION OF ONE URETER.

DR. GEORGE WOOLSEY presented specimens obtained from a man thirty-seven years old, an alcoholic. He denied syphilis, but had had gonorrhœa several times, the last attack having occurred about four months previous to his admission to the hospital. A month after the onset of his attack he began to suffer from frequent micturition and haematuria. Six weeks before he came to the hospital he began to feel a dull, aching pain in the region of the bladder; this pain was fairly constant, and worse during micturition. The urine was passed every two or three hours. The patient was losing flesh and strength.

When he was admitted to the hospital, an examination per rectum revealed that the right lobe of the prostate was enlarged, irregular, and slightly tender. On June 2, 1902, Dr. Eliot opened the bladder above the pubes and found a sessile tumor occupying the region of the trigone and adjacent posterior wall. The tumor felt rather hard, bled freely upon manipulation, and was curetted.

This operation was not followed by any permanent improvement, and when Dr. Woolsey first saw the patient, in July, his condition was pitiable. The urine was foul and filled with blood and pus. The patient was still losing flesh and strength, and had a septic temperature and appearance. Without encouraging him as to the outcome of the operation, he was told that the only hope of cure or relief lay in complete removal of the bladder. This operation was undertaken by Dr. Woolsey on July 18, 1902, the idea being, if possible, to implant the ureters into that part of the bladder-wall which was healthy and could be left, or to save those sections of the bladder-wall where the ureters entered and implant these sections, together with the ureters, into the rectum.

Upon reopening the previous suprapubic wound, which still persisted as a fistula, the bladder was found to be completely filled with a tumor, which bled so profusely that nothing could be done from the inside. The cavity was thereupon packed, and the entire bladder shelled out from its peritoneal covering, without injuring the latter. Upon reaching the ureters, the right ureter was found to be much thickened and dilated and secreting pus. A catheter was sutured into it, and it was allowed to drain into a vessel outside. The left ureter was apparently normal, and it was implanted directly into the rectum, projecting free for one-half of an inch. The original idea of implanting it into a healthy area of bladder-wall or of excising with it a section of the bladder-wall had to be abandoned, because, in shelling out the bladder, its entire blood supply was cut off, and the bladder-wall at the openings of the ureter was involved in the neoplasm.

The patient bore the operation very well. The secretion from the right ureter gradually cleared up. The rectum for a time was intolerant to the urine which was secreted into it by the left ureter, but after two to three weeks had elapsed toleration became fairly well established and the patient was able to hold his urine for several hours. He felt much more comfortable and gained some flesh and strength, although he never left his bed. Towards the end of September he again began losing ground, and on November 2, about three and one-half months after the operation, he died. The autopsy showed a double pyelonephritis. In the left kidney this condition was probably due to an ascending infection from the rectum, although it may have commenced before the operation. Such an infection, Dr. Woolsey said, might probably have been avoided had it been possible to implant with the ureter a small section of the bladder-wall.

The diagnosis of the bladder growth was carcinoma. The patient also had pulmonary tuberculosis. There was some infiltration of the pelvic glands.

SEPTIC PERITONITIS DUE TO THE PRESENCE OF A RUBBER CATHETER IN THE PERITONEAL CAVITY.

DR. WOOLSEY presented specimens obtained from a girl, eighteen years old, who was married on January 1, 1902, and was delivered of a full-term child on March 27 of the same year.

Ten days after her confinement she had a chill and some fever, together with considerable vaginal discharge, and received uterine irrigation at the Lying-in Hospital, where she remained in bed three weeks after labor.

Subsequently, several days before admission, the patient developed symptoms of septic peritonitis, and was operated on by Dr. Woolsey, the abdomen being opened in the median line. He came down upon a mass of thickened omentum studded with several small abscesses, and after separating it from the anterior abdominal wall he found that it consisted of a coil of omentum, about three inches wide, which surrounded a section of rubber catheter. The latter was covered with white incrustations, and its lower extremity was adherent to the fundus of the bladder. The peritoneal cavity contained free serous fluid. The sign of an opening could be discovered on the bladder-wall.

The anterior surface of the uterus was exposed, and a careful inspection failed to show any lesion on its surface or in the uterovesical pouch. On account of the adhesions, its posterior surface was not within reach. The peritoneal cavity showed a diffuse peritonitis, was thoroughly cleansed by irrigation, and drainage made through both flanks. After an infusion of 1000 cubic centimetres, the patient made an uneventful recovery. She could not state whether the catheter had found its way into the peritoneal cavity through the bladder, the vaginal fornix, or the uterus; although an attempt had evidently been made to introduce it into the latter cavity to bring on an abortion.

An examination of the exudate from the peritoneal cavity showed non-pathogenic bacteria, the result of a dirt infection.

BULLET AND WAD OF CLOTHING REMOVED FROM THE PERITONEAL CAVITY.

DR. FORBES HAWKES presented specimens obtained from a boy who had recently been shot by his father. The ball (.32-caliber) entered the body anteriorly, four inches below and an inch and a half to the right of the nipple line. When the patient was brought to the hospital, shortly after receiving his injury, there were few symptoms of shock. His pulse, however, became weak and rapid, and there was distinct rigidity of the right

rectus abdominis muscle. Diagnosis of hæmorrhage was made into the peritoneal cavity.

Acting upon the supposition that the bullet had passed through the liver, an incision was made through the right rectus muscle. This revealed a perforation of the liver. The bullet had fractured the eighth rib, penetrated the pleural cavity, perforated the diaphragm, entered the liver on its upper or outer surface, and emerged at a point corresponding to the Spigelian lobe below. A further search revealed the bullet and a wad of clothing resting just below the posterior peritoneum, about an inch below the liver and just to the inner side of the right kidney. At the time the boy received his injury he wore an over-coat, a sweater, a shirt, and an undershirt, and the wad found with the bullet was made up of a section of all these articles of clothing. The bullet had carried this wad of clothing with it in its passage through rib, pleura, diaphragm, and liver. The hæmorrhage from both liver wounds was stopped by packing.

The patient made an uneventful recovery from the operation. The leucocyte count at the time of operation was 45,000.

DR. HOTCHKISS mentioned a case of shot-wound of the liver operated upon by him where the pistol-ball had passed from in front directly through the right lobe and lodged somewhere in the back of the abdominal cavity, narrowly missing the inferior vena cava and not wounding the intestines. The man recovered, but about eight months later he suddenly died. At the autopsy, which was made by the coroner's physician, the intestines were found filled with blood. The source of the hæmorrhage could not be learned, but it is possible that a small aneurism had developed as the result of his injury, and in the course of time had ruptured. The bullet was never found. Of course this may have been a case of typhoid intestinal hæmorrhage, but the body was removed, and the bare facts as reported were all that could be learned.

Stated Meeting, May 13, 1903.

DR. HOWARD LILIENTHAL in the Chair.

OPERATIVE REDUCTION OF IRREDUCIBLE DISLOCATION OF SHOULDER.

DR. JOHN F. ERDMANN presented a woman, forty-one years of age, who in August, 1902, fell from a wagon, striking upon her shoulder and other portions. The great shortening of small intestine was over the humerus. An X-ray photograph showed a small fragment of detached bone lying anterior and internal to the glenoid fossa. Attempts at reduction by various methods without and with anaesthesia were fruitless. An incision was then made. Upon separating the deltoid and pectoralis major, a mushy, lacerated area filled with blood-clot was exposed. The torn edges of the capsule could not be felt; but the head of the bone and the surgical neck stripped free of peritoneum for a distance of fully two inches down upon the shaft could be palpated very easily. A very rough, excoriated area of bone, about two inches long transversely by three-quarters of an inch wide in the long axis of the humerus, was felt immediately below the head of the humerus, and just above this and to the outer side in the muscular tissue a portion of bone was found. This proved to be the greater and lesser tuberosities, still attached by a few fibrous shreds to the muscle. The capsule of the joint was posterior to the head and neck of the humerus so as to prevent, even in the exposed condition, reduction without a transverse incision of the internal portion; while the biceps tendon, which was ripped completely out of its groove, lay posteriorly and externally, also preventing reduction. The bony fragments were removed, the capsule replaced and sutured with kangaroo tendon, the biceps tendon placed in the shallow and short groove remaining, and the wound sewed, a bit of rubber tissue being used as a drain. The arm

was put up in an abducted position ninety degrees from the body and the forearm slightly flexed. She has now all motion to which this joint is entitled except full abduction.

BULLET WOUND OF THE STOMACH.

DR. P. R. BOLTON presented a man, aged twenty-five years, who was brought into hospital immediately after having been shot at short range with a .32-caliber pistol. His general condition was good. The ball entered the abdomen at the level of the umbilicus through the right rectus muscle.

The abdomen was opened about an hour after the receipt of the wound and was found to contain a moderate amount of blood. There were wounds of the anterior and posterior walls of the stomach about one inch from the greater curvature and two inches from the pylorus; these were closed by Czerny-Lembert sutures. There were two perforations of the transverse colon and two of the small intestine, which were closed by purse-string Lembert sutures. From none of these wounds was there any extensive leakage.

The greater and lesser sacs of the peritoneum were thoroughly flushed and the abdomen closed without drainage. No attempt was made to discover the position of the bullet or to remove it. For five days nourishment was supplied by nutrient enemata, and on the sixth day feeding by the mouth was begun. Recovery was without incident.

TUMOR OF MALE BREAST.

DR. CHARLES H. PECK presented a man, thirty-six years of age, who first noticed a small lump in his right breast about ten years ago. For the past five years it has been enlarging slowly, and for the past month the increase in size has been very rapid. There are no symptoms except the presence of the tumor, which is spheroid, about the size of an orange, distinctly encapsulated, and easily lifted from the deep tissues. Consistency soft and elastic; no enlargement of axillary lymph nodes. The overlying skin is thinned, pigmented, and somewhat adherent; the greater portion of the mass lies below the nipple, which is on the upper

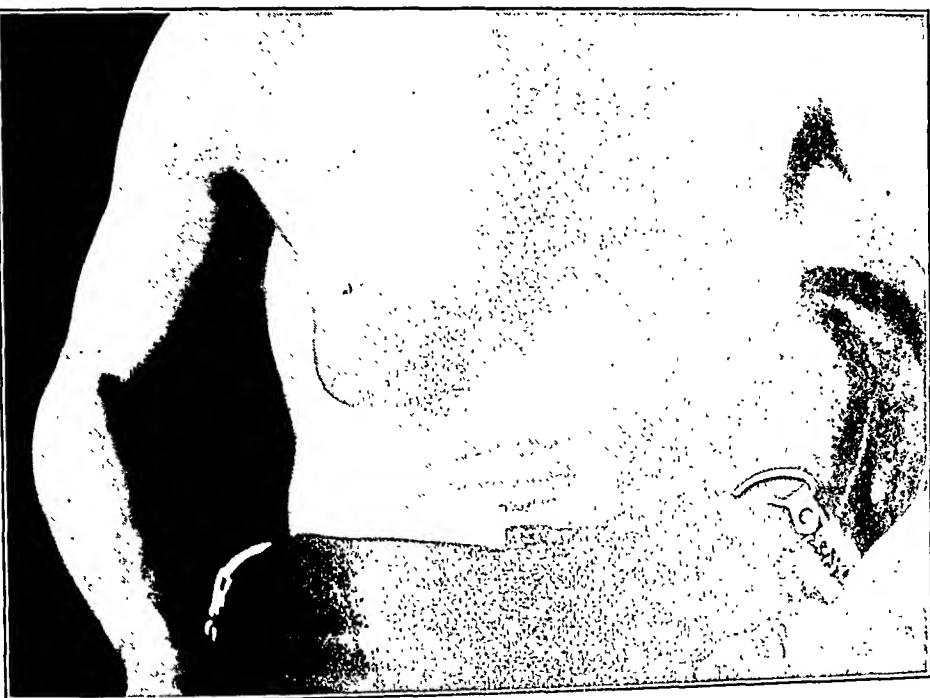


FIG. 1.—Dr. Peck's case. Tumor of male breast.

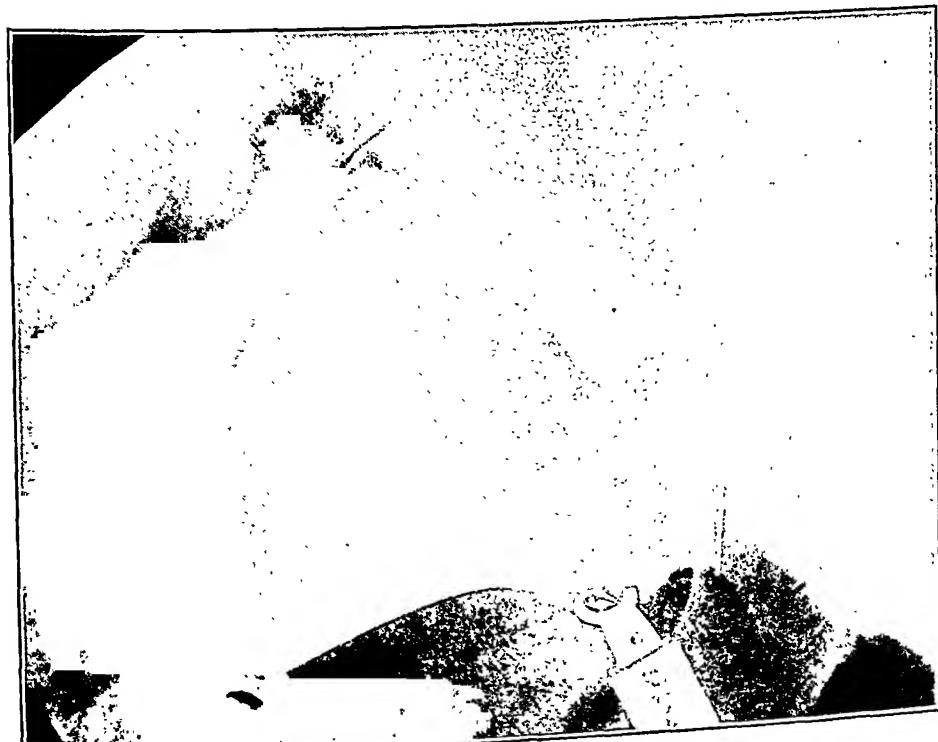


FIG. 2.—Dr. Peck's case. Tumor of male breast.

aspect of the tumor. The mass was excised by an ovoid incision including nipple and all of overlying skin, the tumor and all tissues down to and including the pectoral fascia removed *en masse*. An irregular cavity in centre of tumor contained about three ounces of a clear, dark-colored fluid, the rest was solid tissue; capsule distinct. The wound healed by primary union. Up to the present time no satisfactory pathological report has been obtained, as three competent pathologists have been unable to determine from the sections either the nature of the tumor or the question of its malignancy.

CONDITION OF INTESTINE TWO YEARS AFTER EXTENSIVE RESECTION.

DR. CHARLES H. PECK presented a woman, thirty years of age, who was operated upon July 14, 1901, for gangrene of intestine. Twenty-four hours before a curetting had been performed for incomplete abortion at about three months. The right horn of uterus had been perforated, small intestine prolapsed, and a considerable length was drawn out with placental forceps before it was recognized. Median laparotomy was immediately performed, and the intestine was drawn back into abdomen and left. When first seen by the operator (Dr. Peck), symptoms of diffuse peritonitis were rapidly developing, and patient was in a critical condition. The abdomen was reopened, the pelvis and lower abdomen being filled with coils of grayish-black, gangrenous small intestine, dark-colored fluid, and recent adhesions. The gangrenous gut was drawn out and eight feet five and one-half inches of small intestine resected; end-to-end anastomosis with a Murphy button made; the wound was packed. A faecal fistula developed on the seventh day, closing spontaneously on the tenth day. A ventral hernia which developed in the scar was operated upon April 17, 1903, by excision of cicatrix and suture by layers with chromic catgut; wound healed uneventfully: cicatrix firm.

Inspection of abdominal contents during operation was as follows: The omentum was adherent to cicatrix and also in pelvis. When freed, the intestine was found to be practically free from adhesions; careful inspection of small intestine from

ileocæcal junction upward for several feet failed to reveal any sign of cicatrix, the intestine appearing is smooth and normal as other portions. The great shortening of small intestine was very evident, apparently not more than twelve or fifteen feet remaining. The uterus and appendages appeared normal except for some adhesions and adherent omentum. The nutrition and digestion of patient have been excellent, and she attends to her business regularly.

TRANSACTIONS OF THE CHICAGO SURGICAL SOCIETY.

Stated Meeting, June 1, 1903.

The President, JOHN B. MURPHY, M.D., in the Chair.

THE TREATMENT OF THE COMPLICATIONS ATTENDANT UPON CHRONIC GALL-STONE DISEASE.

DR. JOHN B. DEAVER, of Philadelphia, read a paper with the above title.

DR. WILLIAM J. MAYO, of Rochester, Minnesota, said there were two important questions in connection with surgery of the gall-bladder and biliary passages which were as yet unsettled. First, in what cases shall the gall-bladder be removed? Second, in what cases is it wise to drain the bile to the surface? Should the gall-bladder be removed in the early uncomplicated cases of gall-stone disease, or was it sufficient to drain it for a time until the biliary discharge was sterile? Without going extensively into the physiology of the gall-bladder, there was no doubt but that Murphy was right in believing that one of its functions was to act as a tension bulb, keeping the flow of bile steady instead of intermittent. This was unimportant of itself; but when the gall-bladder was suddenly cut off by a stone impacted in the cystic duct, there were not only symptoms arising from the retention in the cystic cavity, but there was usually some irritation of the liver from the increased tension, and mild infection, as shown in many cases by transient slight jaundice, etc. The liver soon accommodated itself to this change, and when the acute symptoms of obstruction were over, such a gall-bladder could be tied off without liver drainage; but if the cystic duct was not obstructed, and the gall-bladder still persisted in the biliary circulation, in

spite of the stones, the sudden ligation of the cystic duct, without provision for the escape of bile, was liable to increase liver tension and coincidentally the infection of the liver duct, and added this condition to the usual risks of operation. It was altogether probable that in the majority of cases this would do no harm, yet in the exceptional ones, cessation of liver function and death might follow. As stones do not reform after complete removal and drainage, it would seem to the speaker that the excision of the otherwise healthy gall-bladder, on account of gall-stones, subjected the patient to some unnecessary risks unless some provision was made for hepatic drainage. The thick contracted gall-bladder, with obstruction at the cystic duct, had lost its function, and such a gall-bladder was the one in which there was liable to be trouble from mucous fistula, adhesions, cancer, etc. Fortunately, by reason of the obstruction, the liver had become accustomed to the change in the extension, and such a gall-bladder could be removed without biliary drainage. He had never seen harm follow the ligation of the cystic duct in such cases, and this existed in about one-third of the cases as they came to the operating table.

Stones in the common duct were the cause of cholangitis, and drainage of bile to the surface was necessary either by a cholecystostomy, if the cystic duct was sufficiently patulous for the purpose, or by leaving the incision in the common duct open, the latter being the safer method.

To what extent was it necessary to provide bile drainage in cases in which there were no stones in the common duct? Cholecystostomy drained the hepatic duct by the escape of bile to the surface, and all of experience had seen a patient doing badly suddenly relieved by a discharge of bile in a previously dry wound. So true is this, that often, with a patient not doing well, the drains were loosened, hoping to establish bile drainage, and, if one succeeded, recovery usually followed.

He had tried to classify his cases with regard to the necessity of hepatic drainage, and the following was about the position he had temporarily assumed as a result of this study: (1) If the gall-bladder contained bile, and the organ was distensible, if the gall-bladder was removed, bile drainage was provided for by cutting the cystic duct across and leaving it open. If such a patient was very obese, or had degenerative lesions of other

organs, he preferred cholecystostomy. (2) If there were symptoms of cholangitis, even of mild grade, he provided for bile drainage, and if the condition was acute, the drainage must be free. (3) If the gall-bladder contained cystic fluid, but no bile, and the patient had symptoms of cholangitis, he removed the organ, and cut the cystic duct below the obstruction to permit of bile discharge. If necessary, the cystic duct was split down to the common duct. (4) In a few cases he had directly opened the common duct for the purpose of securing liver drainage; but it was very rare that this was necessary, unless there were or had been stones in the common duct, and it was dilated. The cystic duct ordinarily could be advantageously used for the purpose; although in a few instances he had found it necessary to cut it off flush with the common duct, leaving a lateral defect in its wall for drainage purposes. This brought up the question as to how much danger of peritonitis there was as a result of bile leakage into the peritoneal cavity. If there was free gauze drainage, with or without tubage, there was but little danger of peritoneal infection from the bile. He had never seen a case of death from this cause; but the drainage should be attached to the proper point by a catgut suture to prevent its floating away by the bile discharge or displacement by the action of the diaphragm upon the liver. If the common duct was greatly dilated, and after removal of the calculi there was considerable detritus, the end of a rubber drainage tube was inserted into the duct opening and secured by a catgut suture. If this condition did not exist, tubage of the common duct was unnecessary.

To sum up: Cholecystectomy was to be preferred if the patient was otherwise in good condition. If the cystic duct was obstructed and the gall-bladder contained only cystic fluid, ligation of the cystic duct, without provision for hepatic drainage, was safe. If there was any infection of the hepatic ducts, bile drainage was essential.

DR. FRANK BILLINGS, speaking from the stand-point of the internist, said that, given a reasonable certainty of the presence of gall-stones in the gall-bladder or ducts, it called for their removal by means of the surgeon's knife. He would modify that statement, however, to this effect, that where there existed some disease of other organs of the body, as the kidneys or the heart, which would render the use of an anesthetic immediately dan-

gerous to the health of the individual, it was questionable whether operation should be undertaken. If gall-stones were acute in their manifestations, his advice was to wait until the symptoms had diminished or subsided. If attended with jaundice, to wait a reasonable time to see if it did not diminish; and if it did not, to attempt to improve the coagulability of the blood by the use of calcium chloride. In recent years, by means of calcium chloride, the coagulability of the blood had been increased or improved to such an extent as to make a surgical operation much less dangerous than before it was given. He would go farther than Kehr, if he understood him correctly, and say that if there were symptoms of gall-stones in the common duct, and they had subsided, and if following that, within a reasonable length of time, there were farther symptoms or indications of gall-stones, he would urge operation. He understood from the paper read by Kehr at Washington that he would not operate on such cases. While the speaker made this statement from a medical point of view, of operating on gall-stone cases when the evidence was clear that they were present, surgeons should not forget that they owed a great deal of what they knew to-day to Pasteur and Koch. It was the work of Pasteur, Koch, Lister, and others that had enabled surgeons to open the abdomen in these cases and to treat them successfully.

Dr. Billings then recounted briefly the symptoms of cholelithiasis and pointed out some of their peculiarities.

He said the medical treatment of gall-stones was instituted long before surgeons thought of opening the abdomen for the relief of this condition. The Carlsbad treatment had been in vogue for years, and surgeons should not censure medical men too much for sending their patients to Carlsbad or resorting to medical treatment, when it was known that a celebrated surgeon who, two years after operating on his own father for gall-stone, was attacked himself, and, instead of undergoing an operation, went to Carlsbad for treatment.

DR. ARTHUR DEAN BEVAN said that in a discussion as broad as the one on the subject of cholelithiasis, brief conclusions arrived at from a review of one's own experience were in order, and with such an idea in view he presented the following:

"1. Gall-stone disease is due to a mycotic invasion of the bile tracts. Gall-stone disease is exceedingly common. From

his dissecting-room experience, it occurs in 16 per cent. of cadavers.

" 2. In the vast majority of cases of gall-stone disease, the patient does not suffer from the existence of the condition.

" 3. A close parallel cannot be drawn between cholelithiasis and appendicitis, and the conclusions accepted in appendicitis, i.e., that a diseased appendix should in practically all cases be operated on, cannot with equal force be applied to cholelithiasis: (a) Because the disease, in its first manifestations, does not carry with it nearly the amount of danger to the patient as does appendicitis. (b) Because of the enormous number of individuals who have gall-stones many have slight, single, or very infrequent manifestations of the disease, which are speedily recovered from, carry little danger, and a good prospect of permanent recovery.

" 4. As a corollary to the above, the hygienic treatment, i.e., exercise, diet, salines, is indicated in cholelithiasis, as a rule, in the first manifestations of the disease.

" 5. Surgical treatment is indicated when the manifestations of the disease are repeated, and especially when they are frequent and severe. Surgical treatment is demanded in the presence of: (a) An infected gall-bladder: (b) with stone or obstruction of the cystic duct; (c) with stone or obstruction of common duct.

" 6. With stones still confined to the gall-bladder, cholecystotomy with drainage is the operation of choice.

" 7. With stone in the cystic duct, or obstruction of cystic duct, cholecystectomy is the operation of choice.

" 8. With stone in the common duct, choledochotomy with drainage is the operation of choice.

" 9. With stone in both cystic and common ducts, cholecystectomy and removal of stone from common duct, and drainage of common duct, is the operation of choice.

" 10. With obstruction of common duct from chronic interstitial pancreatitis or carcinoma, drainage of the bile tracts through the gall-bladder is the operation of choice.

" 11. In the cases of cholecystitis and cholangeitis simulating gall-stones, drainage of the gall-bladder should be carried out, and with this probability the use of salicylate of sodium, which is excreted through the bile, and has seemed to exert a definite local antiseptic effect.

" 12. To expose the bile tracts, the incision introduced by the

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speaker in 1898, as modified by Weir and Mayo Robson, gives the best access to the region, makes the operation in difficult cases much easier, saves valuable time, and is least likely to be followed by hernia.

" 13. The mortality from gall-stone operations is surprisingly small in uncomplicated cases. The speaker had had no deaths in more than 100 cholecystotomies, and in more than twenty cholecystectomies had had but one death in fourteen cases of obstruction of the common duct.

" 14. The prospects of permanent cure after operative removal of gall-stones are very good. The recurrences of symptoms are almost always due to incomplete operations, i.e., leaving some stones or the doing of a cholecystotomy where a cholecystectomy should have been done.

" 15. Personally, he had seen little evidence pointing to gallstones as a factor in the production of carcinoma, and therefore inclined to the belief that carcinoma favors gall-stone formation, and is the cause and not the effect where these two conditions coexist.

" 16. The modern surgical treatment of cholelithiasis is, with the exception of the surgical treatment of appendicitis, the most valuable addition that has been made to medicine during the last twenty years. Inasmuch as the general practitioner sees the last these cases in their early history, it rests with him whether or not this valuable knowledge will be made the most of and accomplish the greatest amount of good."

REVIEWS OF BOOKS.

DIE TOPOGRAPHIE DER NIERE UND IHRE BEDEUTUNG FÜR DIE NIEREN-CHIRURGIE. Von DR. M. ZONDEK. Berlin: Verlag von August Hirschwald, 1903.

Dr. Zondek has had access to the many valuable specimens in Virchow's museum, and has made a thorough study of the physiology, pathology, and surgery of the kidney.

In the present volume of 100 pages he treats first of the normal topography of the kidney, and discusses the influence of pathological conditions upon the same.

Next is considered the form of the kidney itself and the internal structure of the organ, devoting much space to the distribution of the arterial and venous channels, and the effect of the various surgical inroads upon the same. The last chapter treats of movable kidney.

The work is an important addition to our knowledge of the surgical anatomy of the kidney.

PAUL M. PILCHER.

SURGICAL ANATOMY. A Treatise on Human Anatomy in Its Application to Medicine and Surgery. By JOHN B. DEAVER, M.D., Surgeon-in-Chief to the German Hospital, Philadelphia. Three Volumes. Vol. III. Abdomen. Pelvic Cavity; Lymphatics of the Abdomen and Pelvis; Thorax; Lower Extremity. Philadelphia: P. Blakiston's Son & Co., 1903.

The present volume completes this work, of which the previous volumes have already received notice in this Journal. It speaks well for the liberality of the publishers and the industry of the author that the number of illustrations as originally planned has been increased from two to over five hundred. The quality

of the plates has not deteriorated, but has rather been improved. In particular, the tracheal-like rings which disfigured the arteries in the prior volumes have been omitted in this, and the necessary roundness given by a proper disposition of light and shade. This concession to art has sacrificed nothing of clearness in the teaching quality of the illustrations, and has rendered the drawings more artistic. This work does not pretend to be an exhaustive treatise on anatomy. It contains no account of anomalies nor of embryology, but is rather a work on surgical anatomy, as its title indicates, which is meant to supply the place of the dissecting-room to the practitioner whose anatomical knowledge needs refreshing after an interval, long or short, succeeding his student days. It is the eye of the surgeon which needs instruction rather than his memory of abstruse and unnecessary anatomical facts, and in the absence of the cadaver nothing can serve this purpose better than these volumes of beautiful and for the most part accurate plates. Some references have been made in previous reviews to exaggerations of size in some drawings, but no fault has ever been discovered with the relations of the parts depicted; and it would be strange indeed if into a work of such magnitude some errors did not creep. That they have been so few is a fact worthy of commendation. The distinguished author is to be congratulated upon the close of his labor on this work. No one but an anatomist, and one who has served a long apprenticeship as demonstrator of anatomy, can well appreciate the enormous amount of work which has been required to complete these volumes. The author well says that cadavers suitable for clearly instructive illustrations are hard to find, and under the most favorable circumstances classical dissections are tedious and difficult. No wonder that it has taken nearly fifteen years to bring the author's labor to a close. One must envy him the satisfaction that came to him when the last proofs were read and the final volume went to press. He deserves well of the surgeons, who are indeed his friends and appreciative well-wishers.

ALGERNON T. BRISTOW.

HEATH'S PRACTICAL ANATOMY. A Manual of Dissections.
Ninth Edition. Edited by J. ERNEST LANE, F.R.C.S. Philadelphia: P. Blakiston's Son & Co., 1902.

This old and standard manual of dissections appears in its ninth edition, with some slight modifications and additions. It is a handy book, and comprises in smaller compass than the more pretentious manuals—which, by the bye, are *not* manuals—all the information and technical description that the student needs. Many of the plates are excellent. Some, however, suffer in clearness, as the result of long use in the press, and are more or less blurred and dark. For those students who want a manual or hand-book, and do not care for more expensive works, this old favorite still serves a useful purpose.

ALGERNON T. BRISTOW.

TRAVAUX DE CHIRURGIE ANATOMO-CLINIQUE. Par HENRI HARTMANN, Professeur Agrégé à la Faculté de Médecine, etc., avec la collaboration de B. Cunéo, G. H. Roger, Soupault. G. Luys, P. Lecéne, Leroy, Prat, Delaage. Voies Urinaires, Estomac. 113 Figures dans le texte. Paris: G. Steinheil, MCMIII.

This work is a series of articles by Hartmann and his colleagues of the Service Civiale, at the Lariboisiere Hospital, in Paris, and the contributions cover a wide range of work in genito-urinary surgery of both sexes, to which (and intestinal surgery) the clinic is mainly devoted. The bulk of the volume is taken up by special articles, there being, in addition, a description of the new buildings, wards, etc., and a statistical study of all cases admitted since its opening. Among the more important articles on genito-urinary surgery may be mentioned those on tumors of the fatty capsule of the kidney, the indications, technique, and results of internal urethrotomy, the technique of perineal prostatectomy, and of intravesical separation of the urines. The articles on stomach surgery include sections on the surgical treatment

of non-malignant lesions of the stomach, the influence of gastro-enterostomy on the chemistry of the gastric juice in pyloric ulcer, and the pathological anatomy of cancer of the stomach, besides a report of a case of duodenostomy by Hartmann, the fourth on record.

The variety and number of subjects discussed forbid extended separate comment. They are admirably handled, both from a clinical and pathological stand-point, and a careful analysis of the literature in many of them greatly increases their value. Being mainly based on cases treated in this clinic, abstracts of the histories are attached. Among the genito-urinary articles, Hartmann and Luys have one on intravesical separation of the urines, in which they trace the history of the development of the operation and the instruments of Lambotte, Neumann, and Harris. They have found the separator of Luys, in its modified form, perfectly satisfactory, and the reports of eighty cases, representing 200 tests, are proof to the sceptical of the ease of application and certainty of usefulness of this instrument.

We cannot avoid separate mention, also, of Hartmann's article on non-malignant lesions of the stomach, a most timely article, in which he analyzes the statistics of numerous surgeons, and discusses the various operative procedures, both with respect to their immediate and remote results. He regards gastro-enterostomy as the operation of choice, not only for pyloric stenosis, but also for the large majority of non-neoplastic lesions. His views on the treatment of gastric ulcer are based on a logical conservatism, as is shown in the discussion of operation in the presence of large haemorrhages, direct treatment of bleeding points, excision of the ulcer, and the value of medical treatment, and are practically the same as those of the American surgeons who have had large experience in this field. Soupault's article on the influence of gastro-enterostomy on the chemistry of the gastric juices, a study of ten cases, is interesting in this connection. Cunéo has a chapter on the pathological anatomy of gastric

carcinoma from a surgical stand-point, which is a long and careful study from the laboratory of the hospital, and is finely illustrated, as indeed is the entire volume, by numerous carefully executed drawings. The entire volume will amply repay careful reading.

JOHN H. JOPSON.

DISEASE OF THE PANCREAS: ITS CAUSE AND NATURE. By EUGENE L. OPIE, M.D., Associate in Pathology in the Johns Hopkins University, etc. Pp. 359. Philadelphia: J. B. Lippincott Company, 1903.

It is only within a very few years that the pancreas has been regarded as of sufficient importance to merit special study, although as far back as 1869 Langerhans pointed out peculiarities in its structure that should have served to attract careful investigation. Its contribution to the digestive fluids of the intestine has been deemed its only important function, and physiologists have been content to dismiss it with a few words on the digestive power of pancreatic secretion. More recent studies of the adrenal, thyroid, and other so-called ductless glands, however, and the recognition by surgeons of important pancreatic diseases, have awakened new interest, and the startling propositions of Sajous have placed the study of the pancreas in the very front of the medical stage.

The book now under consideration may well be accepted as an important contribution to this interesting problem, not only on account of the thoroughness with which the subject is treated, but also because of the large amount of original work presented, the painstaking care evidenced in its preparation, and the moderate and judicial manner in which the writer's conclusions are drawn. A glance at the abundant references shows how carefully the preliminary ground has been gone over.

While probably the most absorbing chapters are those dealing with the relation of pancreatic disease to diabetes mellitus.

because of the wide-spread occurrence of the latter and the doubts as to its etiology, of no less importance are the portions devoted to the consideration of fat necrosis, haemorrhagic and interstitial pancreatitis.

One can hardly fail to be convinced that Dr. Opie has proven the islands of Langerhans to be directly accountable for the regulation of carbohydrate circulation and elimination. He does not discuss the method in which this is accomplished, but he does conclude—logically from the facts as he finds them—that the presence of intact islands in fair numbers means the absence of glycosuria, and, conversely, that their destruction is associated with sugar in the urine. This points conclusively to the presence of an internal secretion and places the pancreas in a sense among the ductless glands. He does not claim that all classes of diabetes are of pancreatic origin, but by proving that many are he paves the way for the broader contention.

His experiments on the causes of haemorrhagic pancreatitis are hardly less interesting. The limits of a review forbid a detailed description, but his methods seem to prove that cholelithiasis stands in a direct causative relation: a gall-stone impacted in the diverticulum of Vater being sufficient, when the anatomical relations permit, to cause a flow of bile into the pancreatic ducts, with consequent haemorrhage into the substance of the gland. That this does not occur more often is due to the frequent patency of the lesser duct—that of Santorini.

He recognizes two general varieties of interstitial pancreatitis, an interlobular and an interacinar form,—the latter more often associated with diabetes because of the more frequent invasion of the islands of Langerhans; the former seldom, if ever.

Fat necrosis is treated of at some length, with the conclusion that it is due to the direct action of the pancreatic secretion on fat, the escape of the digestant taking place through the substance of the gland.

The chapters on abnormalities, histology, hyaline degeneration, symptoms, and treatment can only be mentioned.

The author's style is clear, his conclusions convincing, and the type is large and plain. What more need be said?

HENRY GOODWIN WEBSTER.

THE SURGERY OF THE HEAD. By BAYARD HOLMES, B.S., M.D.
8vo, 569 pp.; 14 plates. New York: D. Appleton & Co.,
1903.

This volume is evidently the first of a series to appear under the general heading of Surgical Emergencies. It comprises the more frequent, every-day surgical affections of the head, face, and mouth, and is the outcome of many years of close observation, surgical teaching, and operative experience. The various chapters include complete and detailed descriptions of the surgical injuries and diseases of the head, both congenital and acquired. The amount of space given to the discussion of each subject is proportionate to its relative frequency of occurrence or theoretical importance. Carefully selected reports of clinical cases add much to the value of the work.

Throughout, pathology, diagnosis, and proper methods of treatment, are the three cardinal features.

The sections on fracture of the skull, cerebral compression, and cerebral localization are particularly comprehensive and instructive.

The author is a believer in the occurrence of cerebral concussion as a distinct pathological condition, and describes it as such.

From cover to cover a clear, pleasing, and concise style is maintained, and the original methods of teaching make the book both unique and valuable as a surgical treatise. There are numerous good illustrations.

It is to be hoped that the remaining numbers of the series on Surgical Emergencies will maintain the same stamp of excellence which the first publication has shown.

WALTER A. SHERWOOD.

SURGICAL DISEASES OF THE ABDOMEN. By RICHARD DOUGLAS, M.D., formerly Professor of Gynaecology and Abdominal Surgery, Vanderbilt University, Nashville. Philadelphia: P. Blakiston's Son & Co., 1903.

The present work takes up in detail the etiology of the various diseased conditions of the abdomen, presenting the various discussions which have arisen in regard to each. The classifications are clear and concise; a comprehensive pathology of each condition leads to the symptomatology, in which are presented minute details which could only be learned by a most extensive and intimate knowledge of the literature. The consideration of the indications and contraindications for operative procedure are accurate, brief, and indicative.

Appended is a very complete and extensive bibliography, which marks a most gratifying departure from the usual treatise. The surgical procedure in most cases is indicated, but the author has omitted the technique of the operation as being beyond the scope of the work. The volume consists of 864 very readable pages, the subject-matter itself being expressed in an interesting but at the same time accurate manner.

To the medical student especially the book will be of great value, since it contains details which the larger surgical textbooks so often omit. He will particularly appreciate the accuracy of the various differential diagnoses, which are well shown by the use of tabulated parallel columns profusely scattered throughout the book.

JAMES TAFT PILCHER,

THE SURGICAL TREATMENT OF GASTRIC AND DUODENAL ULCERS.
By B. G. A. MOYNIHAN, M.S. (Lond.), F.R.C.S., England,
Senior Assistant Surgeon, Leeds General Infirmary, etc.
Philadelphia: W. B. Saunders & Co., 1903.

It does not fall to the lot of every surgeon to be able to report his personal experience with such a long list of special cases as

does Dr. Moynihan in the brochure now before us, nor can every one point to such excellent results.

Although the diagnosis of gastric ulcer and its sequelæ has passed beyond the experimental stage, the question of treatment is by no means agreed upon, and any light on the subject is welcome. To operate or not to operate in cases of gastric haemorrhage is as much a moot point as ever, many authorities claiming that surgical interference is seldom, if ever, of real service.

The table of cases here presented is interesting in this connection. The author reports twelve cases of perforating ulcer with six recoveries, sixty-nine cases of gastro-enterostomy with one death, three cases of pyloroplasty with no death, fifteen cases of hour-glass stomach with three deaths, one death following excision of ulcer, and one case of gastroplication with recovery.

He has found gastro-enterostomy an entirely satisfactory method of treatment in the relief of gastric ulcer, most of the sixty-nine cases already mentioned having been operated on for the relief of that trouble.

Pointing to the unsatisfactory results reported after excision and other methods of treatment and the frequent need for secondary interference, he says, "In all cases, therefore, I submit, gastro-enterostomy, and gastro-enterostomy alone, should be performed. Excision is unnecessary, often impossible, always insufficient; and is, therefore, not to be commended."

He prefers the posterior method, accomplished without mechanical aids other than a couple of Doyen's forceps, and uses fine Pagenstecher thread for sutures.

Diagnosis, direct and differential, receives brief but clear mention. In speaking of distinguishing an hour-glass contraction close to the cardia from an obstruction of the lower end of the oesophagus with the common symptom of regurgitation of food, he says, "If the bougie passes over sixteen inches from the teeth, the obstruction does not lie in the stomach." Should not one read "oesophagus"?

The facts of the author's experience and his deductions are so convincing that one is almost persuaded to submit every case of gastric ulcer to the benefits of posterior gastro-enterostomy.

HENRY GOODWIN WEBSTER.

THE PRACTICAL APPLICATION OF THE RÖNTGEN RAYS IN THERAPEUTICS AND DIAGNOSIS. By WILLIAM ALLEN PUSEY, A.M., M.D., Professor of Dermatology in the University of Illinois; and EUGENE W. CALDWELL, B.S., Director of the Edward N. Gibbs X-Ray Memorial Laboratory of the University and Bellevue Hospital Medical College, New York. 8vo, pp. 591. Philadelphia: W. B. Saunders & Co., 1903.

Part I of the present work is devoted to X-ray apparatus and its use in diagnosis. E. W. Caldwell, the author of this part, presents chapters on X-ray tubes, induction coils and controlling apparatus, static machines, fluoroscopy, radiography, etc. His discussion of X-ray tubes is interesting, but at the same time leaves one in doubt as to the superiority of one or the other forms of tubes. He states that any of the ordinary forms of tubes may be used for therapeutic purposes, definition is a matter of no importance whatever, and the regulation of the vacuum need not be so accurate as is necessary for fluoroscopic and radiographic work. Such a statement to the uninitiated is quite confusing, and should be further qualified.

Part II has been prepared by W. A. Pusey, and takes up the therapeutic application of X-rays. The author has digested carefully the experience of others, and reports in detail many cases of his own, with good illustrations of cases before, during, and after treatment with the X-rays. The chapters on Tuberculosis and similar diseases, and Carcinoma in its various forms, are especially interesting and valuable.

The two parts of the book are distinct the one from the other,—the mechanics of the subject being considered from the stand-point of an electrician, and the therapeutics from the stand-

point of a physician. This fact in itself adds to the importance of the work, and makes it more practical.

PAUL MONROE PILCHER.

A LABORATORY TEXT-BOOK OF EMBRYOLOGY. By CHARLES SEDGWICK MINOT, LL.D., D.Sc., Professor of Histology and Human Embryology in the Harvard Medical School. 8vo. pp. 380. Philadelphia: P. Blakiston's Son & Co., 1903.

Embryology is primarily a laboratory study; its facts can be acquired only by spending hour after hour, day in and day out, dissecting, drawing, sectioning, and reconstructing. This the student must do; but he should also, as Professor Minot remarks, continually pass "beyond the direct observations to the conceptions which they justify, and which underlie many important branches of science which are related to, and in large part dependent upon, embryology;" such branches, for example, as morphology, systematic zoology, general biology, and pathology. In view of these interrelations, the first chapter of the book is devoted to "General Conceptions," comprising the following: the morphologic and embryologic characteristics, and the chief modifications, of the vertebrate type; a brief summary of embryologic development; cytomorphosis, including the processes of simple growth, differentiation, regression, and degeneration; an explanation of the general significance of the primal germ-layers; the relations of surface to mass; germ-cells as distinguished from somatic-cells; the theory of heredity; and the law of recapitulation. In Chapter II is explained "the early development of mammals," including the characteristics of the sexual elements; the maturation, impregnation, and segmentation of the ovum; the development of the germ-layers and the subsequent differentiation of their cells into the anlagen of the body tissues and organs. Chapter III deals with the development of the human embryo as a whole, from the time of appearance of the medullary plate to the end of the fourth month; Chapter IV,

covering more than 110 pages, with the study of pig embryos, chiefly by means of serial sections and reconstructions; and Chapter V, with the study of young chick embryos by the same methods. Chapter VI comprises the study of the blastodermic vesicle of the rabbit and the mitotic changes occurring in the ovum of the white mouse; and Chapter VII treats of the histology of the human uterus, its histologic alterations during menstruation and pregnancy, and of the human foetal appendages. The book is completed by a chapter (VIII) on embryologic methods and a useful index.

In every page of the book there is evidence of that scientific exactness, caution, and experience which are characteristic of its author. Such a book could not be written save by one who, like Professor Minot, had devoted years to painstaking research and teaching of the subject; and there is little doubt that students of embryology, be they instructors or undergraduates, who have striven, by means of their laboratory appliances and the ordinary descriptive text-books, to form adequate concepts, not merely of sections and reconstructions, but of what these signify, will thoroughly appreciate the aid obtainable from this book; for it is not a mere laboratory guide, but a manual for use in the interpretation of laboratory data.

Of the 218 illustrations, 147 are original; many of these are full-page plates, and all are exquisitely executed.

JOHN C. CARDWELL.

APPLIED SURGICAL ANATOMY, REGIONALLY PRESENTED. For the Use of Students and Practitioners of Medicine. By GEORGE WOOLSEY, A.B., M.D. New York and Philadelphia: Lea Brothers & Co., 1902.

The author does not claim originality for his book, but at the same time he has used good judgment in the selection of his facts, and has introduced many important surgical principles which make the book eminently practical and useful to the surgeon.

It is designed for both clinical and didactic purposes, and will be a valuable aid to the student, in that it helps to fix in the mind the essential features of anatomy in a practical way, and is well termed Applied Anatomy.

It does not differ from most works on this subject in its arrangement; each region of the body is taken up in order, and the relation of the anatomy to the various morbid processes is duly considered.

The discussion of fractures of the base deserves special mention. It presents clearly and concisely both the pathological and clinical characteristics of these lesions.

The author has, in this volume of 500 pages, presented a work well worthy of careful study.

PAUL M. PILCHER.

TRANSACTIONS OF THE AMERICAN SURGICAL ASSOCIATION. Vol.
xx. Edited by RICHARD H. HARTE, M.D., Recorder, 1902.

As the years go by, medicine and its representing societies have become more systematized and established: and we have arrived at the stage of development in America when we may look backward as well as forward. We have traditions as well as ambitions. Historical matters in medicine are receiving more and more attention. Annual addresses and presidential addresses before medical societies are dealing with history more than ever before. This is because there is more history to deal with, because we are developing a pride in our medical history, and because the value of the past as an index of the future is more fully recognized in its relation to medicine.

An instructive example of this is found in the opening chapter of this volume,—the address of the President, Dr. De Forest Willard. In this address the speaker reviews the history of this society. He calls attention to the first volume of its transactions issued in 1883. That was only twenty years ago: but let us see what changes this short time has wrought in our surgery. Lap-

arotomy was then a rare operation. Listerism and the antiseptic surgery were struggling for recognition. The following sentences have been taken from this first volume of 1883: "May we not be mistaken in regard to the fact that micrococci produce suppuration?" "I have always been a consistent anti-Listeric surgeon; I have never treated a single wound by closure after the Listerian plan." "If it were true that unfavorable symptoms which follow certain operations are due to the presence of bacteria in the wound or in the blood, then the Listerian plan, in my opinion, is the wrong one; it cannot succeed." "I do not think that Listerism is going to die; it is dead; few surgeons will long continue to use it." Another surgeon is quoted as saying, "I am satisfied that this theory of microscopical organisms is not the correct one." "There are Fellows in this Association who are ready to raise their hands and thank God that they have never witnessed the application of Listerism, nor used it."

In 1885, two years later, Sir Joseph Lister was elected an honorary Fellow of the American Surgical Association.

The volume before us contains a splendid collection of scientific papers. In the paper of Park's on perforating gunshot wound of stomach and liver with posterior drainage and recovery is shown the value of drainage in these cases. Harte and Stewart have a paper in which is reported a case of severed spinal cord, treated by suture, in which a partial return of function was secured. This paper gives a full reference to the bibliography of the subject. In the discussion of this subject, Dr. Estes adds two cases from his own experience.

Dr. Moore presents a paper showing why the perineal route is preferable to the suprapubic route in prostatic surgery, both from anatomical and technical reasons. The discussion of this subject brings out the general consensus in favor of perineal prostatic operations, and presents the whole subject in its most advanced light. This is the department of surgery which has made advances of the greatest importance during the past two years.

Another sign of the advancement of American surgery are the papers by Drs. Burrell, of Boston, and Bryant, of New York, on the teaching of surgery. These papers and discussions show a new interest in this subject, and the broad views and well-advanced grasp of our teachers of surgery.

In the same sense, we may call attention to the papers on hospital construction, management, and methods of preserving records, by Drs. Vander Veer, Mosher, Blumer, Richardson, and Elting. Dr. Vander Veer takes the Albany Hospital for his text, and considers the whole subject in a broad and instructive manner. He begins with the ground and the site, and discusses in turn all of the phases of hospital development,—the endowment, the finances, the character of the buildings, the building materials, and the administration of the hospital's affairs.

In a paper on gastro-enterostomy, Dr. William J. Mayo discusses ninety-eight gastro-enterostomies. He speaks of his inability to offer an explanation of the frequency of lung complications following these operations. Stress is laid upon the importance of making the stomach opening at the most dependent part of the greater curvature. Dr. Finney reports a new method of pyloroplasty. The discussion on these papers brings out the advantages and disadvantages of the various methods of gastro-enterostomy.

The paper on the surgical treatment of tuberculosis of the peritoneum by Dr. Ochsner shows that this operation has not fulfilled the expectations of earlier operators. He finds that operation is of value chiefly, and almost solely, for the evacuation of fluid.

Dr. McGraw has a paper on splenectomy for leukæmic enlargement, in the discussion of which Dr. Richardson refers to a successful operation for this condition.

Dr. Murray reports a case of acute suppurative pancreatitis, in which report is given a careful analysis of the fluid secreted through the fistula remaining after operation.

Drs. Harte and Willson report cases of carcinoma limited to the vermiciform appendix, and discuss their relation to appendicitis.

Abdominal hysterectomy is discussed from the surgical standpoint by Dr. Deaver. It is a fortunate thing that this subject is occasionally treated to some real surgical consideration: it seems to have a wonderfully clearing effect upon the perturbed gynaecological atmosphere.

Acetonaemia following acute appendicitis is discussed by Dr. Brewer, who reports a case of this condition. In the discussion, Dr. Deaver contends that the case reported was nothing more or less than a case of sepsis.

Dr. Rixford reports two cases of exophthalmic goitre treated by operation. Dr. Roberts contributes the report of a case of excision of the lumbar lymphatic nodes and spermatic vein for malignant disease of the testicle.

In a paper upon the influence of the Röntgen ray upon the different varieties of sarcoma, Dr. Coley expresses his belief that this is a strong reason for believing in the parasitic origin of this disease. He concludes that the X-ray has a remarkably inhibitory action upon the growth of all forms of tumor, and especially upon the sarcomata. Some cures, which, indeed, if they are cures, seem wonderful. In the discussion of this subject, Dr. Gerster throws light upon the question by calling attention to the fact that before the serum treatment was used and before the X-ray every surgeon had seen so-called sarcomata disappear. Esmarch has recorded a number of cases of the spontaneous disappearance of sarcoma. He also calls attention to the good that iodide of potash is well known to have in supposed cases of sarcoma. In this same line we are all familiar with the large number of cases reported cured a few years ago with arsenic,—and this, too, in the hands of men of high medical standing.

Dr. Fowler discusses, in an excellent paper, the vicious circle following gastro-enterostomy, and describes a new operation for

the prevention of this accident. The operation devised by Dr. Fowler consists in a gastro-enterostomy with entero-enterostomy, to which is added an occlusion of the proximal limb of the gut near the stomach, which thus makes the vicious circle a mechanical impossibility.

This volume also contains papers on the operation for prostatic abscess by Dr. Ransohoff; the implantation of silver filigree for the closure of large hernias by Dr. Meyer; the question of the treatment of the inflamed gall-bladder the same as the inflamed appendix by Dr. Park; shortening of the radius in fracture of the lower end of that bone by Dr. Fowler; cysts in connection with the teeth by Dr. Oliver; arteriorrhaphy for the cure of aneurism, with a report for four cases successfully treated by this method of operation, by Dr. Matas; the present status of the X-ray as a means of diagnosis and as a therapeutic agent by Dr. Bevan; morcellement and bisection of the uterus in complicated abdominal hysterectomy by Dr. MacDonald; myomectomy versus hysterectomy by Dr. McCosh; the choice between the suprapubic and the infrapubic methods of reaching surgical lesions of the pelvic organs by Dr. Richardson; the abdominal route for approaching rectal tumors by Dr. Abbe.

This volume contains also an index of Volumes i to xx, representing the transactions of this society for the past twenty-two years.

JAMES P. WARBBASSE.

THE PRACTICE OF OBSTETRICS BY AMERICAN AUTHORS. Edited by CHARLES JEWETT, M.D., Professor of Obstetrics and Gynæcology in the Long Island College Hospital, Brooklyn. New York. New (second) edition, revised and enlarged. 8vo, pp. 775.

In this second edition this important work has been materially enlarged and in many parts rewritten.

A new chapter on the operation of version has been added by John O. Polak, of Brooklyn, and, while little that is new is added to the technique of an operation probably centuries old, the chapter is of especial value by reason of the practical treatment of the subject and the illustration of the various steps in the procedure by photographic reproductions of the operation as it actually occurs with the use of a foetus, a half-pelvis, and the hand of the operator.

In obstetric surgery, the greatest advances have been made in recent years, and Hunter Robb, of Cleveland, in two of several chapters in this section, describes the plastic perineal operations and the Cæsarean section, the Porro operation, and symphysiotomy in a manner which merits commendation. With the progressive and continued improvement in the technique and results of the Cæsarean operation, this has superseded as the operation of choice both the Porro and symphysis procedures. Hysterectomy is not as essential to-day as it was formerly because of the better results with the Cæsarean section, the application of symphysiotomy seems now to be limited to those cases where labor has actually begun, and therefore a just estimate of the proportion of passage to passenger can be made, and where, with a true conjugate of not less than three inches, but little more room is needed to effect a delivery. Craniotomy, too, has to be weighed in the balance; and if the mother's condition is so precarious that one of the major sections would probably cause her death, the crushing operations should not be restricted to a dead child. The steps of the Cæsarean section, illustrated in a manner similar to those of version, just mentioned, would enhance the value of the descriptive matter.

The index is unusually complete, nearly 5000 titles being classified; but the list of the plates and engravings is omitted, and with nearly 500 illustrations, many of them new, of exceptional interest, and accurate reproduction, this omission makes them difficult to find and lessens their value.

This particular volume is essentially a Brooklyn production. Dr. Jewett, and his associates, Drs. Browning, Bristow, Bartley, Dickinson, de Forest, Hyde, Polak, and Van Cott, all on the teaching staff of the Long Island College Hospital, have each contributed in a greater or less degree to the sum total of the work so ably edited by Dr. Jewett.

HENRY P. DE FOREST.

CORRESPONDENCE.

AN AID TO THE LOCALIZATION, BY X-RAYS, OF FOREIGN BODIES EMBEDDED IN THE TISSUES.

EDITOR ANNALS OF SURGERY.

WHILE several excellent methods have been devised whereby an object embedded in the tissues can be accurately localized, the surgeon is often in need of some simple method, requiring no special apparatus, whereby he can rapidly determine, by the use of the fluorescent screen, whether, for example, a broken needle is on the palmar or dorsal aspect of a metacarpal bone.

It has been advised that two views, at right angles to one another, should be taken; but this is not always satisfactory, owing, in the case of the hand, to all the metacarpals being projected together in the view with the palm at right angles to the screen, giving rather a confused image, while the object, if small and situated about the centre of the palm, even if at all visible, appears blurred and indistinct.

Another method recommended is to compare the size and sharpness of the image of the embedded body when the hand is turned with its palmar and dorsal surfaces respectively towards the screen; but this plan also often leaves one in doubt, with the flickering and not very brilliant illumination, when using the screen.

As is well known, the relative position of the image of bones and embedded object alters, according to whether the part be held directly in front of the point of emergence of the rays or above or below it; and while this is annoying where exact localization is desired, it occurred to me that use might be made of this fact, in order to determine the depth of the object in the tissues relatively to the bones.

Owing to the rapid divergence of the rays from the luminous point of the tube, it follows that the shadow of any object not actually in contact with the sensitive surface of the screen will change its position when the screen, carrying with it the object, is moved up and down vertically in front of the tube; and the farther the object is from the screen, the greater will be the apparent movement of the shadow on the screen.

When, therefore, the embedded object is farther from the screen than the bones, its shadow will move with greater rapidity than that of the bones, and thus, when the screen carrying with it the part to be examined is raised, the shadow of the object will rise relatively to the bones, and fall when the screen is lowered. On the other hand, when the object is nearer the screen than the bones, the shadow of the bones will rise, when the screen is raised, relatively to the object, and fall when the screen is lowered. If, then, as in practice one naturally does, we take the bones as our fixed points, the image of the embedded object will rise and fall with the screen, relatively to the bones, when the embedded object is on the tube side of the bones; and will appear to fall, relatively to the bones, when the screen is raised, and rise when it is lowered, when it is on the screen side of the bones.

We may put the matter shortly for convenience in working, that, if the shadow of the object rises and falls with the screen, the object is on the tube side of the bones, and when it moves in the opposite direction to that of the screen, it is on the screen side of the bones.

When the shadow of the foreign body does not move relatively to the bones, it must be close to if not actually embedded in them.

Of course, the matter is a perfectly obvious one; but, as I have not seen any mention of it in text-books or journals, I thought it well to draw attention to it as a simple but efficient

means of determining in the tissues the relative depth of foreign bodies to the bones.

JOHN A. C. MACEWEN, M.B., C.M.

GLASGOW, SCOTLAND.

THE EXPOSURE OF THE POSTDUODENAL PORTION OF THE COMMON BILE DUCT.

EDITOR ANNALS OF SURGERY.

I WISH to report what I believe to be a new procedure to facilitate exposure of and dealing with the postduodenal portion of the common bile duct. It consists in longitudinal division of the peritoneum to the right of the descending portion of the duodenum, separation with the fingers and turning forward and to the left of the latter. I have done this three times on the cadaver and obtained an excellent exposure of this portion of the duct up to its duodenal entrance. The large vessels remain on the posterior wall, the duct follows the duodenum. The posterior aspect of the head of the pancreas can be approached by the same method.

I believe the above procedure to be superior to the transduodenal route of Mayo or the supraduodenal route of Haasler, being less likely to cause an infection than the former, being farther away from dangerous structures than the latter, and being easier and giving better access than both.

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Assistant in Clinical Surgery, University of California.

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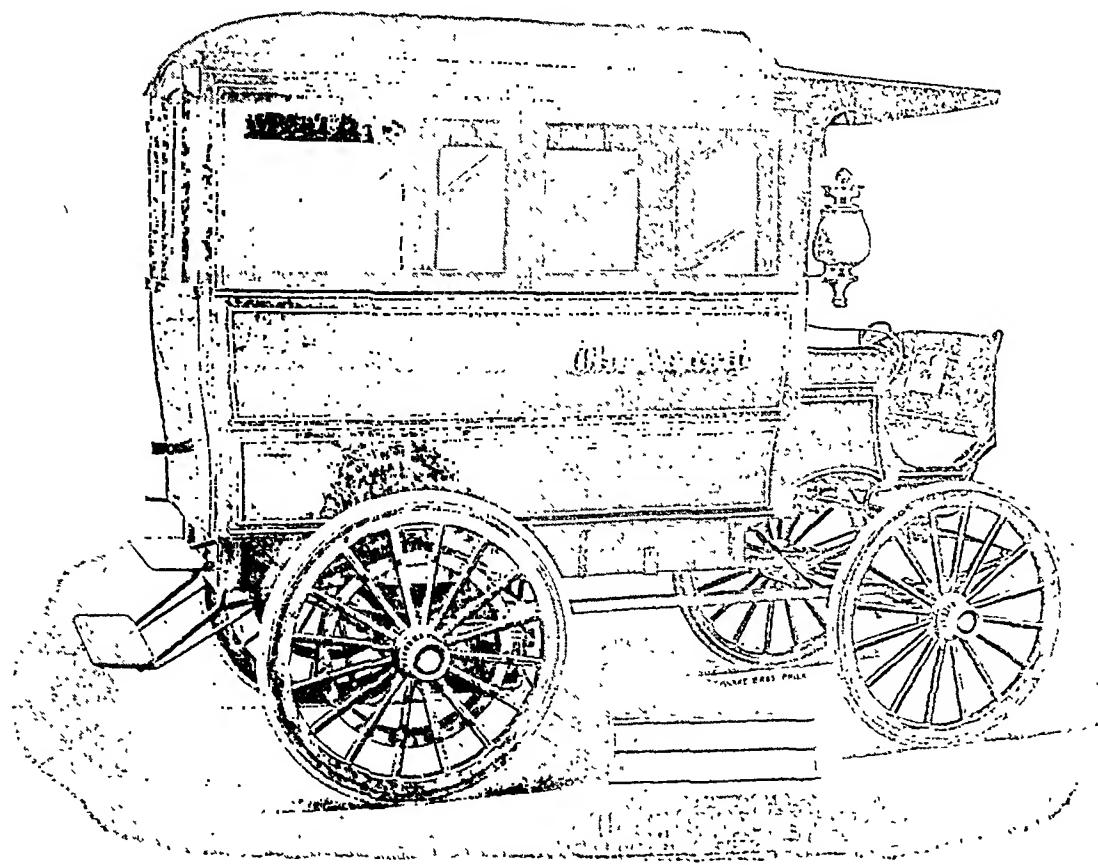
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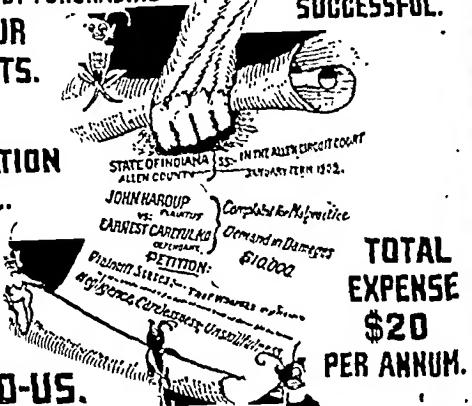
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ORAL SEPSIS AS A CAUSE FOR PERNICIOUS ANÆMIA.

In an article on this subject by William Hunter, M.D., Edin. F.R.C.P., London, published in *The Lancet* (January 27, 1900), the author gives the following conclusions:

"1. Pernicious anaemia is a special form of chronic blood-poisoning—a toxæmia.

"2. It is the result of a special infection of the digestive tract, especially of the mouth and stomach, and probably, although to a less degree, of the intestine.

"3. The chief source of infection is through the mouth from long-continued and neglected cario-nerotic conditions of the teeth, and sometimes, possibly, from stomatitis arising from other causes.

"4. The usual effect of this infection is a chronic infective catarrh of the mouth and stomach, which may in time lead to deeper-seated changes,—e.g., ulcers of the mouth and tongue, chronic glossitis and atrophic changes in the tongue, or chronic gastritis, with atrophy of the gastric glands.

"5. The evidences of the infectivity of the organisms of dental decay are overwhelming.

"6. The infection is chiefly streptococcal, and probably derives its special character from being of a 'mixed' character.

"7. Such infection the more readily occurs if the stomach or intestine is already, from any cause, the seat of disease.

"The above conclusions suggest certain new considerations in regard to treatment, of which the chief one is the importance of minute attention to the hygiene of the mouth, and especially of the teeth, with the immediate removal of every source of infection."

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This question has been asked so many times that the following brief outline is submitted for the benefit of the public.

Chemical Lymph is a synthetic compound produced from the cell salts of iron, manganese, calcium, magnesium potassium, and sodium, with distilled water as a menstruum. A specific lymph is prepared for the treatment of each disease for which it is recommended, by varying the proportions of these salts of the blood to meet the requirements of the disease conditions.

These compounds are not simply solutions of the salt in the menstruum, but each is put through a series of elaborate chemical processes, aided by electricity, which makes of it a delicate lymph replete in all the salts of the blood, in shape for hypodermic use; to be immediately absorbed; taken up by the circulation, and become a part of the blood without any untoward effects.

It propagates rich new blood, supplying to it its own nourishing elements, cleanses the blood, and the blood cleanses the whole system. It is a sterilized food for cells, restores vitality to the exhausted cells, overcoming all conditions of faulty metabolism.

By the faithful use of the indicated compounds of this lymph, the conquest of the tubercle bacilli is accomplished; the processes of ulceration and bone disease are arrested: the poisons of rheumatism, gout, serofula, and syphilis are eliminated; normal force and power are restored to weakened or paralyzed nerves; dyspepsia, torpid liver, and gastritis are cured with surprising promptness, and diabetes is overcome without regard to diet.

This line of treatment should become a sheet-anchor to the surgeon, because it puts a patient in the best possible condition for operation, and quickly restores him to normal health after operation. This has been demonstrated in cases.

I have employed this method of treatment for all chronic conditions constantly during the past year. Results have been all that could be desired. Of course, I do not claim that it has cured cases where the ravages of disease have caused destruction of tissues, but even in such cases the destructive processes have been stopped, and undestroyed structures have been restored to a condition to resist the farther inroads of disease.

This shows what has been accomplished in my own private practice. My year's records show the treatment and cure of four cases of chronic muscular rheumatism, each within six weeks; six cases of chronic articular rheumatism in from two to three months; four neurasthenics in periods ranging from one to four months; three torpid livers very promptly restored to normal action; a very severe case of chorea cured in two months, and five dyspeptics restored to normal powers of digestion. Other cases of paralysis, impotence, etc., now under treatment, are showing marked improvement.

In three cases of rheumatoid arthritis so far advanced as to cause ligaments, the progress and the condition of the

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